

CHILD AND FAMILY SERVICES REVIEWS

2001–2004



A Mental Health Analysis

PREPARED BY:

Jan McCarthy
Erika Van Buren
Marisa Irvine

*National Technical Assistance Center for Children's Mental Health
Georgetown University Center for Child and Human Development*

*Technical Assistance Partnership for Child and Family Mental Health
American Institutes for Research*

CHILD AND FAMILY SERVICES REVIEWS

2001 – 2004

A Mental Health Analysis

PREPARED BY:

Jan McCarthy
Erika Van Buren
Marisa Irvine

*National Technical Assistance Center for Children's Mental Health
Georgetown University Center for Child and Human Development
Washington, DC*

*Technical Assistance Partnership for Child and Family Mental Health
American Institutes for Research
Washington, DC*

AUGUST 2007

This document is funded by a cooperative agreement with the Child, Adolescent and Family Branch of the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration with supplemental support from the Administration for Children and Families, U.S. Department of Health and Human Services. The views expressed do not necessarily reflect the views or policies of the funding agencies and should not be regarded as such.

PUBLISHED BY:

National Technical Assistance Center for Children's Mental Health
Georgetown University Center for Child and Human Development
3300 Whitehaven Street, NW, Suite 3300
Box 571485
Washington, DC 20057

Technical Assistance Partnership for Child and Family Mental Health
American Institutes for Research
1000 Thomas Jefferson St., NW, Suite 400
Washington, DC 20007

AVAILABLE FROM:

National Technical Assistance Center for Children's Mental Health Web site
http://gucchd.georgetown.edu/programs/child_welfare_initiative/mental.html

Technical Assistance Partnership for Child and Family Mental Health, Child Welfare Web site
<http://www.tapartnership.org/advisors/ChildWelfare/default.asp>

FOR MORE INFORMATION CONTACT:

Jan McCarthy, MSW
Director of Child Welfare Policy
National TA Center for Children's Mental Health
Georgetown University Center for Child and Human Development
(202) 687-5062 • jrm33@georgetown.edu

Kim Helfgott, MA
Child Welfare Resource Specialist
Technical Assistance Partnership for Child and Family Mental Health
(202) 403-5879 • khelfgott@air.org

SUGGESTED CITATION: McCarthy, J., Van Buren, E., Irvine, M. (August 2007). *Child and Family Services Reviews: 2001-2004: A Mental Health Analysis*. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health and the Technical Assistance Partnership for Child and Family Mental Health, American Institutes for Research.

Notice of Nondiscrimination

Georgetown University provides equal opportunity in its programs, activities and employment practices for all persons and prohibits discrimination and harassment on the basis of age, color, disability, family responsibilities, gender identity or expression, genetic information, marital status, matriculation, national origin, personal appearance, political affiliation, race, religion, sex, sexual orientation, veteran status or any other factor prohibited by law. Inquiries regarding Georgetown University's nondiscrimination policy may be addressed to the Director of Affirmative Action Programs, Institutional Diversity, Equity & Affirmative Action, 37th and O Streets, NW, Suite M36, Darnall Hall, Georgetown University, Washington, DC 20057.



Acknowledgments

The authors would like to acknowledge the foresight of the staff workgroup from the Administration for Children and Families and from the Substance Abuse and Mental Health Services Administration that met in 2003 and 2004 to work on strategies for improving access to quality mental health and substance abuse services for children and families in the child welfare system. This workgroup requested that we conduct a mental health analysis of the Child and Family Services Reviews (CFSR) findings. We would also like to acknowledge the good work of the authors, research staff, and a social work student who assisted with the April 2004 version of this analysis: Anita Marshall, Bianca Jay, Melissa Parsons, and Cassandra Cason. The April 2004 document was written before CFSR Final Reports and Program Improvement Plans were available from all States.

This mental health analysis benefited greatly from review by two family representatives, Stephany Bryan and Teri Toothman. Kim Helfgott, Child Welfare Resource Specialist, Technical Assistance Partnership at the American Institutes for Research, provided great insight and suggestions about the format and organization of the analysis.

Finally, we appreciate the work of the States that are using the CFSR process and their Program Improvement Plans as an opportunity to improve mental health services for children and families who are involved with the child welfare system.



Table of Contents

Executive Summary	1
Introduction	9
How to Use This Document	11
Methodology	13
SECTION 1 TRENDS IN FINAL REPORTS	14
Trends in Service Delivery	14
Required Mental Health Screening/Assessment of Children in Foster Care	14
Provision of Services to Meet Mental Health Needs.....	18
Rural Issues.....	21
Family Involvement and Services for Families	21
Permanency and Stability.....	23
Administrative and Management Trends	24
Coordination and Collaboration.....	24
Training	28
Funding	29
Providers	31
Data Collection.....	31
SECTION 2 TRENDS IN PROGRAM IMPROVEMENT PLANS	33
Inclusion of Mental Health Issues in PIPs	33
Comprehensive Strategies to Improve Mental Health Services	34
Trends in Service Delivery	35
Assessment of Child and Family Mental Health Needs.....	35
Identification of Service Gaps and Building Service Array and Service Capacity.....	37
Service Planning for Children and Families	39

Family Involvement in the Planning and Delivery of Services	39
Services for Families	40
Permanency and Stability	40
Administrative and Management Trends	41
Collaborative Efforts	41
Systems of Care Replication	42
Training	43
Funding	44
Providers	46
Policy Development and Implementation	46
Tracking and Monitoring Services Received and Child and Family Outcomes Achieved	47
SECTION 3 SUMMARY OF CONTINUING CHALLENGES AND OPPORTUNITIES	49
Challenges and Opportunities for Specific Trends	50
Additional Challenges	53
Additional Opportunities and Solutions	54
SECTION 4 ISSUES FOR FURTHER CONSIDERATION AND STUDY	56
Disproportionality and Cultural Competence	56
Evidence-based Practices	57
Provider Issues	58
Family Involvement and Services for Families	58
Substance Abuse Services	59
APPENDICES	60
Appendix A CFSR Process, Structure and Additional Resources	60
Appendix B CFSR Measures - Outcomes, Indicators, and Systemic Factors for Round 1	63
Appendix C Changes in CFSR for Round 2	66
Appendix D Methodology	69
Appendix E List of Acronyms	72
Appendix F Systems of Care	73



Executive Summary

The Child and Family Services Reviews (CFSR), conducted by the U.S. Department of Health and Human Services in partnership with State governments, is a results-oriented, comprehensive monitoring review system designed to assist States in improving outcomes for children and families who receive services from public child welfare systems.¹ The CFSR focuses on safety, permanency, and well-being. It acknowledges that enhancing a child's healthy development and giving families the tools they need to care for their children will increase the likelihood of achieving these goals. Most children who enter the child welfare system have experienced significant trauma and have a high prevalence of mental health needs; however, only about one-fourth of those with diagnosed mental health needs receive specialty care.²

This Mental Health Analysis, based on a review of 52 Final Reports and 52 Program Improvement Plans (PIPs),³ includes the following sections in sequence:

- A discussion of mental health service delivery and management trends noted in the Final Reports (**Section 1**) and PIPs (**Section 2**)
- A summary of the mental health challenges and opportunities for reform across all States (**Section 3**)
- A discussion of issues for further study (**Section 4**)

The Mental Health Analysis discovered trends across States and is not intended to be a source of in-depth information about individual States. The findings demonstrate an urgent need for mental health reform and describe collaborative strategies for beginning this reform.

¹ *General Findings from the Federal Child and Family Services Reviews* (See <http://www.acf.hhs.gov/programs/cb/cwmonitoring/results/index.htm>.)

² Burns, B. J., Phillips, S. D., Wagner, H. R., Barth, R. P., Kolko, D. J., Campbell, Y., & Landsverk, J. (2004). Mental health need and access to mental health services by youths involved with child welfare: A national survey. *Journal of the American Academy of Child and Adolescent Psychiatry*, 43(8), 960.

³ Final Reports and Program Improvement Plans (PIPs) were reviewed from 50 States, the District of Columbia, and Puerto Rico. See Appendix A for a further definition of Final Reports and PIPs.

SECTION 1 TRENDS IN FINAL REPORTS

Trends in Service Delivery

Mental Health Screening and Assessment

The Reports indicate that although 16 States required a mental health screening or assessment at or near entry into foster care, only **one** (1) State's CFSR Final Report clearly indicated that all children entering foster care actually received one. Practice in 40 States was inconsistent; some children entering foster care received mental health assessments, and others did not. In 11 States, we could not determine from the Final Reports whether children entering foster care were screened and assessed for mental health issues.⁴

Mental Health Services

All 52 CFSR Final Reports noted that the provision of mental health services to children in the child welfare system was inconsistent. Some children in each State received services, and others did not. In all but **two** (2) States, a scarcity of mental health services was noted. Several services were mentioned most frequently as lacking:

- Substance abuse services for children and families, individual adults and youth, women and their children (22 States)
- Treatment for youth who have been sexually abused or have sexually offended (18 States)
- Treatment foster homes (17 States)

⁴In its summary of the challenges identified with respect to the well-being indicators for the States reviewed in 2002-2004, the Children's Bureau found that inconsistency in conducting mental health assessments was a challenge for 69% of the States. (See <http://www.acf.hhs.gov/programs/cb/cwmonitoring/results/index.htm>.)

⁵*General Findings from the Federal Child and Family Services Reviews*, p. 13 (See <http://www.acf.hhs.gov/programs/cb/cwmonitoring/results/index.htm>.)

Rural Issues

Sixteen (16) States reported challenges faced in rural areas, a lack of providers, barriers created by distance, and a lack of specialized mental health services.

Family Involvement and Services for Families

Only **three** (3) Final Reports discussed involving parents and families in mental health service delivery, and only **seven** (7) mentioned a lack of mental health services for family members. This is a significant finding when compared with two of the Children's Bureau summary findings:

- A common challenge in almost every State was the involvement of fathers, mothers, and children in case planning.
- States had insufficient services for parents, particularly substance abuse assessment and treatment services and mental health services.⁵

Even though few Final Reports discussed the lack of mental health services for birth families, 14 States introduced measures in their PIPs to address the mental health needs of family members (see Section 2 of this report).

Permanency and Stability

Thirty-three (33) State CFSR Final Reports demonstrated that many system challenges coalesced around the goals of permanency and stability for children. The complex behavioral health needs of children, along with the lack of early

diagnosis, lack of specialized providers to address needs, and insufficient well-trained and supported foster parents and social workers led to placement disruptions, instability, and difficulty in establishing and reaching a permanent goal. According to several States, children with emotional and behavioral challenges often were not considered ready for adoption, placement resources were few, and efforts were not made to identify adoptive homes for them. Reunification was limited by the availability of mental health and substance abuse services for parents, and reentries of their children into care were attributed to the same services deficits.

Administrative and Management Trends

Coordination and Collaboration

The majority of CFSR Final Reports (38) described the efforts of child welfare agencies to collaborate with other child-serving systems at both the system level (around management issues) and the individual child and family level (around service coordination). Although some States' system level collaborative efforts achieved positive results, these efforts (e.g., interagency teams, special initiatives, shared funding, Memoranda of Agreement) were not able to resolve all ongoing service coordination issues for children and families. The Reports emphasized how important it is for collaboration to be an ongoing process to resolve problems and issues as they arise.

Training

Twenty-six (26) State CFSR Final Reports identified training as a major strategy for preparing staff, providers, and parents (foster, adoptive, kin, and birth) to meet the mental health needs of children and families in the child welfare system.

Funding Issues

Eleven (11) States reported that the current economic climate, state budget deficits, and/or managed care reduced access to appropriate mental health services. In contrast, **10** States described a number of funding strategies to strengthen mental health services for children and their families.

Providers

Final Reports described a widespread shortage of mental health providers skilled in treating the special issues presented by children and families in the child welfare system. Final Reports noted an insufficient supply of child psychiatrists (**12 States**) and providers who accepted Medicaid (**11 States**).

Data Collection

Only **10** Final Reports discussed data collection, and very few of them explained how tracked data have been or will be used for program implementation, monitoring, and improvement efforts. However, by the time States were developing their PIPs, almost half of them (**23 States**) discussed the type of mental health service data they planned to track and the specific monitoring and data collection strategies to be used.⁶

⁶See Section 2 of this report, Tracking and Monitoring Services Received and Child and Family Outcomes, p. 47.

SECTION 2 TRENDS IN PROGRAM IMPROVEMENT PLANS

Inclusion of Mental Health Issues in PIPs

Every State Program Improvement Plan (PIP) included at least some discussion of mental health issues, and almost all the PIPs included one or more goals and action steps related to mental health. Although only half the PIPs listed their PIP team members, all but one of those States (25 States) included mental health stakeholders on the PIP team. Fifteen (15) States identified a need for technical assistance with mental health issues.

Comprehensive Strategies to Develop Mental Health Service Systems

When a PIP described three or more statewide strategies or action steps that focused on improving mental health services, we categorized this as a comprehensive strategy. Twenty-four (24) of the 52 PIPs reviewed were taking a comprehensive approach to strengthening mental health services for children and families in the child welfare system. These States were engaged in many of the strategies described in this report.

Trends in Service Delivery Assessment of Child and Family Mental Health Needs

Thirty-six (36) States identified strategies for improving the assessment of child and family mental health needs. The majority of these States focused on screening and

assessment tools. About one-third of them were strengthening existing comprehensive family assessment processes to include attention to child and family mental health needs. Because most of the PIPs discussed screening and assessment simultaneously, it is not clear whether the strategies they described were about the initial screen (for problems that require immediate attention and further evaluation) or a more comprehensive behavioral health assessment (to address a child's mental/emotional and developmental strengths and needs).

Identification of Service Gaps and Building of Service Array and Service Capacity

Consistent with their service deficits, 21 State PIPs proposed to develop some or all of the following services:

- Addiction services
- Therapeutic foster care
- Treatment for youth who have been sexually abused
- Services for sexual offenders
- Intensive, in-home, community-based services
- Behavioral health services for youth in foster care

Some of these States (14) planned to aggregate findings from individual child and family assessments to identify the array of services needed. Others (16) were conducting a statewide resource inventory to identify service strengths and service gaps. Eight (8) States were expanding the continuum of mental health services through Medicaid and managed care strategies. Five (5) States described

strategies for helping children and families access existing services. **Three (3)** were expanding the availability of evidence-based practices, and **three (3)** were strengthening supports for foster families to increase placement stability.

Service Planning for Children and Families

Eleven (11) State PIPs described a variety of efforts to improve child and/or family service planning processes. Proposed strategies included these:

- Providing training
- Increasing the number of available case managers
- Using the wraparound process
- Formalizing assessment protocols
- Adopting family-centered, strength-based, and culturally competent service planning processes

Family Involvement and Services for Family Members

Although the lack of involvement of fathers, mothers, and children in the planning and delivery of services was identified by the Children's Bureau summary of findings from the 2001-2004 reviews as a challenge for the vast majority of States,⁷ only **six (6)** of the 52 State PIPs identified strategies for improving family involvement in the planning and delivery of mental health services.

Services for Families

Although only **seven (7)** CFSSR Final Reports noted a lack of mental health services for parents, **14** State PIPs described efforts to improve services for families:

- Identifying families' mental health needs early in the process
- Developing new services
- Making linkages to the adult mental health system
- Implementing treatment models that provide services and supports to all family members

Fourteen (14) of the 26 States that listed their PIP team members included family representatives on their teams.

Permanency and Stability

Eight (8) States discussed the importance of improving mental health services to achieve permanency, stability, and reunification and proposed several solutions:

- Strengthening mental health services and supports
- Providing 24/7 crisis stabilization services, care coordination, and intensive in-home services
- Expanding the availability of mental health services at the point of entry into the child welfare system
- Training staff on the special mental health needs of children in foster care

⁷ *General Findings from the Federal Child and Family services Reviews*, p. 10 (See <http://www.acf.hhs.gov/programs/cb/cwmonitoring/results/index.htm>.)

Administrative and Management Trends

Collaborative Efforts

Thirty-seven (37) States proposed collaborative strategies to find solutions to system-level problems and to improve access to mental health services:

- Community-level cross-system partnerships (e.g., network of community hubs that provide access to cross-system services)
- State-level cross-system governing bodies
- Memoranda of Agreement
- Integration of funds

Two (2) States were restructuring their State agencies to consolidate services for children into one department.

Systems of Care Replication

Twenty (20) States were working to coordinate services across systems, develop policy to ensure access to appropriate treatment, and implement community-based mental health systems of care for children and families. **Sixteen (16)** States reported adopting the system of care values and framework to achieve a seamless statewide, cross-agency mental health system.⁸

Training

Thirty-nine (39) State PIPs proposed training as a strategy for improving mental health service delivery. Many States were training on the use of mental health screening and assessment protocols.

Eleven (11) States proposed training foster parents about behavioral health issues, and several were institutionalizing their staff

and foster parent training programs by partnering with schools of social work and developing statewide child welfare training academies (**4 States**).

Funding

Nine (9) PIPs described how they would use funding strategies to improve access to community-based behavioral health services, provide individualized and coordinated care, expand the infant mental health model, and train foster parents. The most frequently cited strategy (**6 States**) for developing systems of care was the development and coordination of financial resources across child-serving systems.

Providers

A significant contributing factor to the provider shortage was the lack of providers who participated in the Medicaid program. Given the shortage of mental health providers experienced and skilled in treating the special issues presented by children and families involved with child welfare described in the Final Reports, we expected to find multiple strategies in the PIPs for addressing this problem; however, only **four (4)** States described strategies for recruiting providers or reducing the administrative burden on Medicaid providers.

Policy Development and Implementation

Our review of the PIPs revealed that States value policy as a strategy for improving mental health services for children, youth, and families and for accomplishing change at both the service delivery and systems levels. **Twenty-one (21)** States have enacted

⁸See Appendix F for information about systems of care.

policy to strengthen the assessment of child and family mental health needs; 13 have proposed or revised policies to develop, expand, or create mental health interventions; and several States have implemented policies to improve coordination, collaboration, and oversight within and across systems.

Tracking and Monitoring Services Received and Child and Family Outcomes Achieved

Twenty-three (23) PIPs discussed tracking and monitoring mental health services. They were tracking receipt of services, functional outcomes, quality of care, and level of care. Several specific monitoring and data-sharing strategies were described in the PIPs:

- Documentation of mental health needs in case plans
- Use of existing quality assurance systems
- Supervisory case reviews
- Systematic entry of mental health data in management information systems
- Documentation of mental health needs and services in electronic case plan reporting systems

SECTION 3 SUMMARY OF CONTINUING CHALLENGES AND OPPORTUNITIES

Our review of the 52 CFSR Final Reports and Program Improvement Plans confirmed the need to better meet the mental health needs of children and families in the child welfare system and to focus attention both on system level improvements and on services for individual children and families. Every PIP mentioned mental health issues, and almost all of them included goals and action steps related to mental health.

Challenges

Final Reports described **continuing challenges**:

- Accessibility to mental health assessments and services
- Involvement of families in the mental health services for their own children and in system level planning
- Coordination of services across systems
- The negative impact of state budget deficits
- A shortage of appropriate mental health providers, especially in rural areas
- Achieving permanency and stability for children with behavioral health needs

Solutions

The PIPs provided the opportunity to address these challenges, describing a number of **solutions** that States were working on to adequately meet the mental health needs of children and families. Almost **half** the States were engaged in comprehensive strategies (three or more action steps) to improve mental health service delivery. Solutions were described for these issues:

- Improving mental health assessments
- Identifying service gaps
- Expanding the array and accessibility of mental health services for children and families
- Increasing family involvement
- Strengthening cross-system collaboration
- Developing or expanding existing community-based systems of care
- Offering training and staff development
- Tracking and monitoring the services received and the outcomes achieved

SECTION 4 ISSUES FOR FURTHER CONSIDERATION AND STUDY

The findings of this analysis are based solely on information that was available in the CFSR Final Reports and PIPs. We know that States may be doing significant work that was not fully reported. Acknowledging the limitations of the information available to us, we note several crucial issues that would benefit from further study.

Disproportionality and Cultural Competence

Only **three (3)** Final Reports and PIPs discussed how to ensure that mental health services for children and families in the child welfare system are culturally competent. This is of concern because of the disproportionate presence of children of color, especially African American and Native American children, in the child welfare system and the lower use of mental health care by African American youth cited in another national study.⁹ Further study of the use of mental health services by children of all cultures is needed.

Evidence-Based Practices

Although the Final Reports and the PIPs mentioned services that have some evidence base (e.g., treatment foster care, multi-systemic therapy, school-based mental health services, the wraparound process), we found that only **three (3)** States described concerted efforts to implement evidence-based practices that

work for children in the child welfare system. It would be interesting to study further whether, and how, States are exploring the use of evidence-based practices through their PIPs.

Provider Issues

The Final Reports and PIPs clearly identified a scarcity of mental health services in States and a shortage of mental health providers experienced and skilled in treating the special issues presented by children and families involved with child welfare. And yet, our review found only a few States that were working to strengthen provider networks. It will be extremely difficult to put new services in place (even if there is a funding source) without a strong network of qualified providers. Further exploration of provider issues is needed.

Family Involvement in Service Planning and Services for Family Members

Successful treatment requires child and family engagement in the process and a commitment to change. Given this, it is important to explore further why only **six (6)** PIPs discussed strategies for improving family involvement in the planning and delivery of mental health services.

Only **seven (7)** CFSR Final Reports noted a lack of mental health services for parents. Further study is needed to understand why so few States noted this when a primary barrier to reunification is a lack of adequate services and supports for parents to address substance abuse and mental health needs.

⁹Garland, A. F., Landsverk, J. A., & Lau, A. S. (2003). Racial/ethnic disparities in mental health service use among children in foster care. *Children & Youth Services Review, 25*(5-6), 491-507.



Introduction

The Child and Family Services Review (CFSR), conducted by the U.S. Department of Health and Human Services in partnership with State governments, is a results-oriented, comprehensive monitoring review system designed to assist States in improving outcomes for children and families who receive services from public child welfare systems.¹⁰ The CFSR identifies strengths and needs within State programs, as well as areas in which technical assistance can lead to program improvements. The CFSR process is managed at the Federal level by the Children's Bureau in the Administration for Children and Families.

What's the connection between the CFSR process and mental health?

The CFSR focuses not only on safety and permanency but also on well-being. It acknowledges that enhancing a child's healthy development and providing families with the supports and tools they need to care for their children will increase the likelihood of achieving safety, permanency, and stability.¹¹ The CFSR expects that States will provide the services needed to achieve child well-being.

Most children who enter the child welfare system have experienced significant trauma. For those who are placed out of their homes, the trauma of separation from their families and moves within the foster care system itself often lead to additional trauma. These vulnerable and at-risk children have a high prevalence of mental health needs. A review of the research literature by Landsverk and colleagues suggest that between one-half and three-fourths of children entering foster care exhibit behavior or social competency problems that warrant mental health care. There is also evidence that this high rate of need may be anticipated for children served by child welfare who remain in their own homes.¹² The National Survey of Child and Adolescent Well-Being (NSCAW) provides the first national estimates of mental health need and service use in the child welfare population. NSCAW determined that nearly

¹⁰ *General Findings from the Federal Child and Family Services Reviews* (See <http://www.acf.hhs.gov/programs/cb/cwmonitoring/results/index.htm>.)

¹¹ The Children's Bureau analysis of ratings associated with permanency and stability found significant association with Item 23 (mental health of child). Greater permanency and stability in living situations was associated with having mental health service needs adequately assessed and addressed. (See www.acf.hhs.gov/programs/cb/cwmonitoring/results/genfindings04/ch2.htm.)

¹² Landsverk, J. A., Burns, B. J., Stambaugh, L. F., & Reutz, J. A. (2006). *Mental health care for children and adolescents in foster care: Review of research literature* (pp. 1-2). Seattle, WA: Casey Family Programs.

half (47.9%) of the children ages 2 to 14 with completed child welfare investigations ($N = 3,803$) had clinically significant emotional or behavioral problems. The study also determined that only one-fourth of these children with mental health needs received any specialty mental health care during the previous 12 months.¹³

Why conduct a mental health analysis of the CFSRs?

Recognizing the intersect among the child welfare, mental health, and substance abuse systems, the Administration for Children and Families and the Substance Abuse and Mental Health Services Administration formed a workgroup of staff from both agencies in 2003 to identify common concerns between the two Federal agencies, share information, and work on strategies to improve access to quality mental health and substance abuse services for children and families in the child welfare system. This workgroup asked the National Technical Assistance Center for Children's Mental Health at Georgetown University and the Technical Assistance Partnership for Child and Family Mental Health at the American Institutes for Research to conduct a mental health analysis of the CFSR findings. The initial analysis, begun in 2003, was based on a review of Final Reports (38 States) and Program Improvement Plans (28 States) that were complete and approved at that time. Since then, all on-site reviews and Program Improvement Plans (PIPs) in the first round of the CFSR have been completed. This updated analysis (2007) includes all 50 States, the District of Columbia, and Puerto Rico. During the six month period prior to on-site review, each State completes a Statewide Assessment which analyzes state data and is a valuable source of information on policy issues. This mental health analysis does not focus on the Statewide Assessments. Instead it reviews the Final Reports which describe findings from the CFSR and the PIPs which identify the changes the State has committed to make. The second round of CFSRs began in spring 2007. Findings from the second round are not included in this analysis.

As this analysis shows, the CFSRs thus far have identified an urgent need for mental health reform. They also provide an opportunity for multiple child-serving agencies and families to work together to reform the system and improve outcomes for children and families.

¹³Burns, B. J., Phillips, S. D., Wagner, H. R., Barth, R. P., Kolko, D. J., Campbell, Y., & Landsverk, J. (2004). Mental health need and access to mental health services by youths involved with child welfare: A national survey. *Journal of the American Academy of Child & Adolescent Psychiatry*, 43(8), 960.



How to Use this Document

As we reviewed the findings from the CFSR Final Reports and the PIPs, we sought answers to specific questions about mental health screening and assessment, mental health services, and the extent to which mental health issues are addressed in the PIPs. The information in this report summarizes the responses to these questions and identifies other trends that emerged from the Final Reports and from the PIPs.¹⁴

- **Section 1** describes trends related to mental health issues found in the 52 CFSR Final Reports.
- **Section 2** describes trends related to mental health issues found in the 52 Program Improvement Plans.
- **Section 3** summarizes the continuing mental health challenges and opportunities described in the Final Reports and the PIPs.
- **Section 4** identifies issues for further consideration and study.

Within **Sections 1** and **2**, we address service delivery issues first, followed by the administrative and management issues that surfaced in the analysis.

It is important to note that Section 1 acknowledges many challenges and problems (findings from Final Reports). It provides a picture of a “state of the States” between 2001 and 2004. Section 2 identifies PIP strategies and potential solutions for the challenges described in Section 1. When the results from the second round of the CFSRs begin to appear, we will learn more about the effectiveness of the strategies proposed in the first-round PIPs. We hope that the second round will provide outcome information about the impact on children and families of the strategies to improve mental health services.

This analysis is not intended as a source of in-depth information about individual States. The format and content of the Final Reports and the PIPs allowed only an analysis of cross-state trends. We hope that knowledge of these trends will allow individual states to examine where they fit and also serve as a catalyst for State and local child welfare and mental health systems to work together with families and youth, community-based organizations, and other stakeholders on ways to improve their systems.

¹⁴State Final Reports and Program Improvement Plans were reviewed from 50 States, the District of Columbia and Puerto Rico.

For most of the trends described, we include the number of States (no individual State names) engaged in one or more activities related to the trend. In identifying the States in which a trend applies, we were limited by the information available in the CFSR Final Reports and the PIPs. Many of the trends may apply to a greater number of States than indicated in this analysis; however, we counted only States that provided information to confirm the trend. Sometimes the Final Reports and the PIPs describe inconsistent trends, both across different States and within individual States.

NOTE: For a more complete explanation of the CFSR process itself, see Appendices A, B, and C. Appendix A also includes a searchable online library of the CFSR Final Reports and PIPs from each State. Appendix E lists the acronyms used in this analysis.



Methodology

We followed a series of steps to identify, organize, and analyze relevant material from the 52 Final Reports and PIPs:

1. A detailed search of each Final Report and Program Improvement Plan was conducted to identify relevant content to review and summarize. In particular, specific child and family well-being outcomes and specific systemic factors¹⁵ were pulled from the reports and reviewed in their entirety for information addressing mental health issues.
2. An additional word search was conducted to locate information about mental health issues and initiatives in other sections of the CFSR Final Reports and the PIPs.
3. Codes were created to help organize and label the trends in the content that was reviewed and to formulate categories for the trends that were emerging. These categories provided the organizational framework for this analysis report.
4. The generation of categories, and the subsequent analyses of State trends, involved an iterative process of review, discussion, and consensus seeking among the authors—a common procedure used in qualitative research.
5. Both Atlas ti and Access Software packages were used to extract material, organize content, and categorize themes and trends from the CFSR Final Reports and the PIPs.

Please see Appendix D for a detailed explanation of the search parameters and analyses procedures used to complete this process.

¹⁵These sections included Well-Being Outcome 3 (children receive adequate services to meet their physical and mental health needs), Item 23 (mental health of the child); Well-Being Outcome 1 (families have enhanced capacity to provide for their children's needs), Item 17 (needs and services); Systemic Factor 5, Service Array (Items 35-37); and Systemic Factor 6, Agency Responsiveness to the Community (Items 38-40).

SECTION 1

Trends in Final Reports

SECTION 1 is based on an analysis of the 52 CFSR Final Reports. It discusses the following issues:

Trends in Service Delivery:

- Required mental health screening and assessment of children in foster care
- Provision of mental health services to meet mental health needs
- Rural issues
- Family involvement and services for families
- Permanency and stability

Administrative and Management Trends:

- Coordination and collaboration
- Training
- Funding
- Providers
- Data collection

TRENDS IN SERVICE DELIVERY

In the analysis of the 52 CFSR Final Reports, we sought answers to four critical questions:

1. Does State policy *require* mental health screening or assessment of children in foster care?
2. Do children in foster care *receive* an initial formal mental health screening or assessment?
3. Are adequate services provided to meet the identified mental health needs of children in the CFSR case sample?
4. Is there a scarcity or lack of mental health services to meet the needs of children in the CFSR case sample?

When a Final Report provided consistent information about any of these four questions, we counted it as a *Yes* or *No* response. When a Report provided inconsistent information (e.g., stakeholder perceptions varied, individual children's experiences were so different that a conclusion could not be drawn), we categorized this as demonstrating *Inconsistent Practice* because both positive and negative practices were noted in the Final Report. If we were unable to find a reference to the question in the Final Report, we categorized the response as *Cannot Determine*.

Required Mental Health Screening and Assessment of Children in Foster Care

Given the prevalence of mental health needs for children in foster care, CFSR Final Reports were reviewed to determine whether State policies required these children to receive a mental health screening or assessment. The Reports indicated that **16** States required mental health screening or assessment at or near entry into foster care

and five (5) did not. However, as figure 1 shows, in the majority of State Final Reports (31 States), it was not possible to determine whether the States required mental health screening or assessment.

The States requiring screening and/or assessment differed in which children were assessed, in who conducted the assessments, and in the timeframes for providing screening and assessment.

Four States required that *certain groups of children* be assessed (e.g., children in certain age groups; children whose parental rights had been terminated; children who had suffered from sexual abuse, serious physical abuse, or mental illness). In **one (1) State**, a developmental assessment met the requirement for very young children.

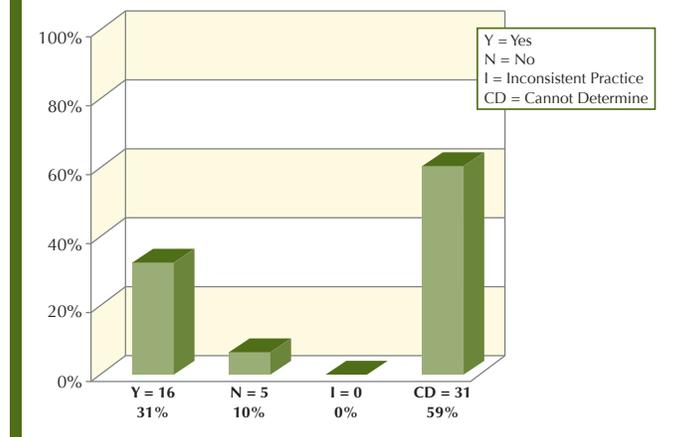
States differed in *who conducted the assessments*, from the child's social worker to a licensed mental health professional trained in children's assessments. **One (1) State** was using an Initial Family Assessment (IFA) to replace its then-current investigation and assessment process. The IFA required social workers to assess children's cognitive, developmental, and emotional functioning. The State anticipated that this would strengthen the social worker's attention to children's mental health issues.

The *timeframes* within which assessments had to be conducted also differed among States. **One (1) State** required an initial mental health screening within 24 to 48 hours of entry into foster care and continuing assessment of mental health needs during monthly contacts with the child and foster parents. **Two (2) States** required mental health assessments within 30 days for children entering care, followed by an annual mental health assessment as long as the child remained in custody. **One (1) State** generally conducted new assessments when a child changed therapists or programs. **Two (2) other States** required assessments within 60 days of entering care, and **one (1)** required psychological assessments within 90 days of entry into foster care.

In six (6) of the 16 States that required screening and/or assessment, stakeholders cited several problems areas:

- It was difficult to obtain mental health assessments for children.
- The quality of the assessments needed to be improved.
- Long waiting lists that delayed access to timely assessments were compounded by the length of time it took to receive the results.

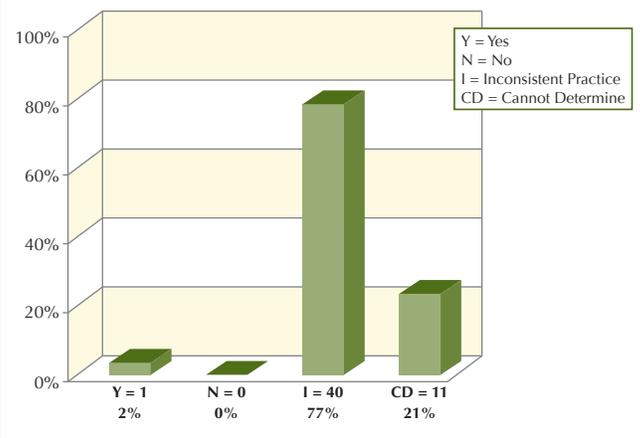
Figure 1. Mental Health Screenings or Assessments Required (N = 52)



- Screening occurred, but there was a lack of in-depth follow-up assessment when needed.
- Assessments were so difficult to schedule that social workers made decisions about a child's mental health needs without input from mental health providers.
- Access to mental health assessments in rural areas continued to be challenging.

CFSR Final Reports were reviewed to determine whether children entering foster care actually received a mental health screening and/or assessment, given that 16 States required these assessments (figure 2). Only **one** (1) State's Final Report indicated clearly that all children entering foster care received an initial formal mental health screening or assessment; however, **none** of the Reports stated that children did not receive a screening or an assessment. Instead, information from almost all the States (40) showed that practice was inconsistent. Some children received mental health assessments and others did not. In 11 States, it could not be determined from the Final Reports whether children were screened and assessed for mental health issues. **Five** (5) States described positive results from the screening and assessments. Multiple problems resulting from not consistently conducting mental health assessments were cited by 18 States.

Figure 2. Mental Health Screenings or Assessments Received (N = 52)



Five (5) States described the following positive results from conducting assessments:

- Individualized mental health needs of children and families were met.
- Needs were identified as soon as the child came into custody, and services were provided.
- Mental health evaluations occurring prior to placement were effective in identifying physical, educational, and mental health issues that affected placing children in the least restrictive environments to meet their needs.

Four (4) States noted that the agency's risk assessments, conducted as part of the maltreatment investigation, were not sufficiently comprehensive to capture unique needs and underlying problems in the family, such as mental health needs, substance abuse, and domestic violence. **One** (1) of these States was therefore piloting an Integrated Assessment Tool. **Two** (2) of the States incorporated mental health assessments in each child and family comprehensive assessment. **Two** (2) States were working with Early Periodic Screening, Diagnosis, and Treatment (EPSDT) providers to enhance mental health, dental, and physical health screenings for children served by the child welfare system. **One** (1) State

monitored the appropriateness of the treatment received and adapted the child and family service plan as needed to address a child's mental health needs.

Eighteen (18) States noted one or more of the following problems that resulted from not conducting assessments:

- The lack of initial assessment resulted in mental health needs not being met or children being hospitalized.
- Agencies lacked a thorough assessment to guide treatment and placement decisions.
- Agency workers made decisions about a child's mental health needs without input from mental health providers.
- It was difficult to reunify children in a timely manner and to ensure that youth successfully transition to independent living.
- Assessments needed to enhance placement stability were not available.
- Some children were discharged from care without having their mental health needs identified and addressed.
- The mental health needs of some family members were met, but not others.
- Hearings to terminate parental rights were delayed while waiting for psychological evaluation of parents.
- Case plans for children in juvenile justice did not address their mental health needs.
- Children did not receive timely mental health treatment.

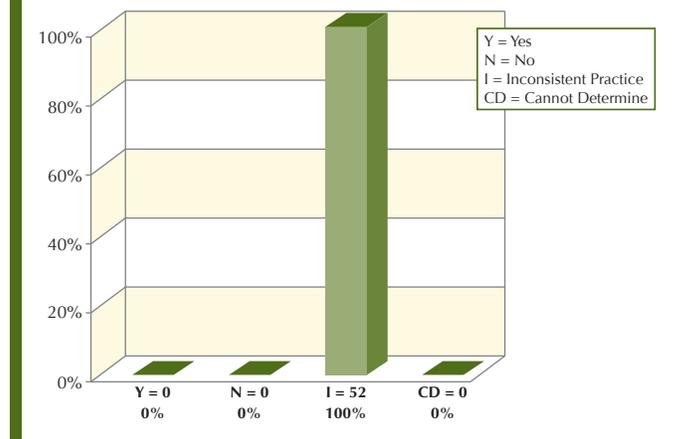
Reasons cited for *not* providing assessments included the child's age, the availability of mental health resources, difficulty in getting assessments done, long waiting lists for assessments, and delays in assessment and treatment. In **four (4)** States, reviewers found that even children who had been exposed to traumatic events and those who showed evidence of potential mental health problems were not consistently assessed when they entered placement. This included children who were described as having been shot, sexually abused, victimized, and rejected; who appeared depressed; who had Attention Deficit Hyperactivity Disorder (ADHD); who had witnessed domestic violence and a parent's suicide attempt; who had lived on the streets; who exhibited autistic behaviors; and who lived with a mother with bipolar disorder. Stakeholders in **one (1)** State noted that local agencies tended to address children's mental health needs when problems occurred rather than assess a child's potential for mental health-related problems.

In **15** States, reviewers and stakeholders indicated that even when mental health needs were assessed, needed services were not provided or were ended prematurely or no follow-up monitoring was provided. In **one (1)** State, reviewers described situations in which assessments showed risk of harm to children because of substance abuse, mental illness, or domestic violence, but services were provided neither for the children nor the parents.

Provision of Services to Meet Mental Health Needs

CFSR Final Reports were reviewed to determine whether children in the CFSR case sample (living in their own homes and in foster care) received adequate services to meet their mental health needs (figure 3). The Final Reports demonstrated that mental health services were not consistently accessible to children and families in the child welfare system on a statewide basis. **No Report** stated clearly that all children received or did not receive services to meet their mental health needs. Many States (18) listed a range of available mental health services, but no State reported that these services were available to all families and children who needed them. Even States that reported the general availability of services often reported long waiting lists to access them. Many services that were more commonly available were those that were traditionally part of community systems and did not address the unique needs that children and families in the child welfare system may have presented.

Figure 3. Provision of Adequate Mental Health Services to Meet Needs (N = 52)



Eighteen (18) States offered a combination of the following range of services to meet the mental health needs of children and families:

- Outpatient services
- Individual, family, and group counseling/therapy
- In-home family therapy
- Community mental health services
- Personal case management
- Therapeutic post-adoption support
- Wraparound for children with serious emotional disturbances (SED)
- Crisis care
- Day treatment
- Psychological testing
- Psychiatric evaluations (for all family members)
- Attachment evaluations
- Medication monitoring
- Services for children who have been sexually abused
- Sexual offender treatment

- Therapeutic foster homes
- Residential care
- Inpatient services
- Substance abuse assessment and services
- Mental health services for uninsured families
- Anger management
- Batterer's treatment services

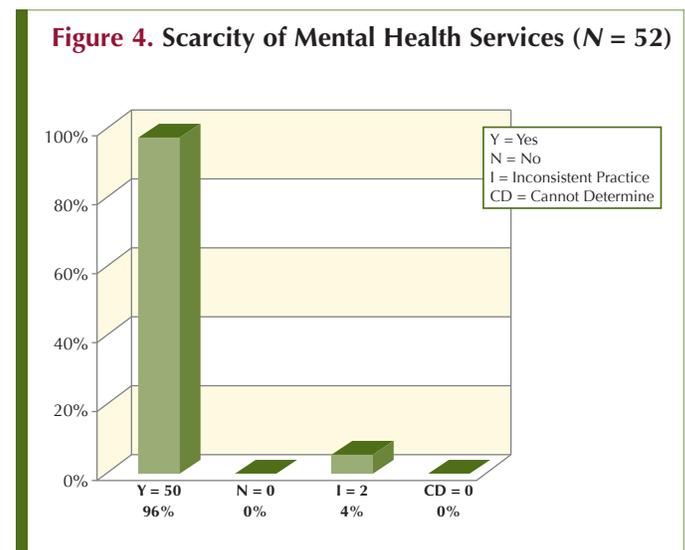
Even though the services listed above were available to some extent, 15 States reported waiting lists from four weeks to eight months for certain mental health services:

- Services ordered by the court
- Mental health evaluations
- In-home counseling
- Parent aid services
- Psychiatric services
- Psychological evaluations
- Trauma services
- Early childhood services
- Medicaid cards

One (1) State described long waiting periods for services, even after children had been assessed and their specific needs had been identified. Another State reported that it often took up to four weeks to obtain a child sexual abuse forensic examination.

In addition to addressing mental health services for the individual children in the CF SR case sample, the Final Reports also discussed the general scarcity of mental health services in the State or locality (figure 4). All but **two (2)** State Final Reports described a lack of mental health services. The Reports noted that some services were consistently scarce.

Twenty-one (21) States reported a lack of specialized mental health services for children in both foster care and child protective services (CPS), including the lack of interventions to address the trauma resulting



from maltreatment and separation of children from their families. **Eleven (11)** States described a dearth of services for families whose children were removed because of parental substance abuse, as well as for adolescents in care who abuse substances. **Three (3)** States identified the lack of mental health services, substance abuse services, and housing as major barriers to the timely reunification of families.

Even though States may have provided certain services, their capacity may not have met the need. **Thirty-three (33)** States noted an insufficient supply of one or more of the services listed below. Those services mentioned most frequently as insufficient are listed first:

- Substance abuse services for children and families, individual adults and youth, women and their children (**22 States**)
- Treatment for youth who had been sexually abused or had sexually offended (**18 States**)
- Treatment foster homes (**17 States**)
- Mental health services for children that were available statewide (**15 States**)
- Psychiatric evaluations and services (**10 States**)
- Treatment of adolescents with serious emotional disorders and serious behavior problems who could not live at home (**8 States**)
- Placement resources and community-based services for children with developmental disabilities and difficult behaviors—MH/DD (**8 States**)
- Culturally relevant and appropriate services, bilingual services, services for immigrant population (**8 States**)
- Crisis intervention services for foster parents to prevent placement disruptions (**7 States**)
- Mental health services for parents (**7 States**)
- Local community-based residential treatment facilities for children and youth with mental health and substance abuse treatment needs (**6 States**)
- Mental health services for youth transitioning from residential care to community-based placements, services and supports to assist youth in moving to less intensive levels of care, and intensive community-based services for children with serious emotional disorders (**5 States**)
- Day treatment, after-school programs, and other home-based services (**4 States**)
- Psychological evaluations (**3 States**)
- Respite care services (**3 States**)
- Inpatient psychiatric care (**1 State**)
- Services for parents with mental retardation or dually diagnosed parents (**1 State**)
- Group homes for children of all ages (**1 State**)
- Services for gay, lesbian, bisexual, and transgender (GLBT) youth (**1 State**)
- Medication management for children in their own homes (**1 State**)
- Post-adoption services (**1 State**)
- Therapeutic recreation (**1 State**)

Rural Issues

Sixteen (16) States reported that their rural areas faced many of the same challenges as urban and suburban areas; however, distance introduced yet another hurdle. These States reported the majority of mental health providers clustered in and around urban areas, a paucity of providers in the rural areas, and long waiting lists. Many providers were unwilling to relocate to rural areas. **Three (3)** States reported that children and families in need of specialized treatment sought services outside the county. A half-day of driving to and from a services site was not uncommon in many rural areas. Lack of transportation was noted as a significant barrier to services in **two (2)** States. States described the difficulty in keeping families engaged in family therapy when children were placed at great distances from their homes. Of particular concern to States was the lack of the following specialized services in rural areas:

- Psychological evaluations
- Psychiatric evaluations
- Crisis shelters
- Residential treatment facilities
- Therapeutic foster care
- Substance abuse treatment
- Sexual abuse treatment

Family Involvement and Services for Families

Family Involvement

In the case-level analyses conducted by the Children's Bureau, the ratings that States achieved on Permanency Outcome 1 (children have permanency and stability in their living situations) were significantly associated with *the involvement of children and families in case planning (Item 18)*. Very strong associations were also found for the relationship between ratings for Item 18 and Safety Outcome 2 (children are safely maintained in their homes when possible and appropriate).¹⁶ Even though these data clearly demonstrated the value of family involvement in case planning, the Children's Bureau summary of findings from the 2001-2004 reviews¹⁷ indicated that a common challenge in almost every State ($N = 35$) was the involvement of fathers, mothers, and children in case planning.

In our review of the 52 CFSR Final Reports, we found minimal discussion specific to the involvement of parents and families in mental health service delivery and service planning. Only **three (3)** States mentioned it. **Two (2)** of these States described an inconsistent level of

¹⁶ *General Findings from the Federal Child and Family Services Review, Case-Level Analyses* (See www.acf.hhs.gov/programs/cb/cwmonitoring/results/genfindings04/ch2.htm.)

¹⁷ *General Findings from the Federal Child and Family Services Reviews*, p. 10 (See <http://www.acf.hhs.gov/programs/cb/cwmonitoring/results/index.htm>.)

family involvement across localities, and **one** (1) described encouraging parents to participate in a child’s medical appointments, therapy sessions, and school meetings.

One (1) State identified the following as barriers to involving families in case planning:

- High caseloads, resulting in less time to devote to involving parents
- Perception by the CPS workers that family engagement in case planning is “therapy” and not the role of the worker
- Perception by the CPS workers that families were not motivated to become involved

Services for Families

In its summary of findings, the Children’s Bureau noted that Well-Being Outcome 1 (families have enhanced capacity to provide for their children’s needs) was substantially achieved for only 48.2% of the children reviewed between 2002 and 2004 ($N = 1,735$ children).¹⁸ The Children’s Bureau summary also affirmed service delivery for parents as a challenge to the States, indicating that the States were found to have insufficient services for parents, particularly substance abuse assessment and treatment services and mental health services.¹⁹

Our review of the 52 CFSR Final Reports partially confirmed this finding. As noted above, **22** States indicated an insufficient supply of substance abuse services; however, only **seven** (7) Final Reports mentioned insufficient mental health services for parents.

Four (4) State Final Reports described inconsistency in identifying and providing for the service needs of families and a focus on services for the child rather than for other family members. **One** (1) State indicated that mothers with developmental disabilities were not able to receive the services and support they needed to resolve child abuse and neglect issues. **Another** State surveyed parents whose children were in foster care and learned that **26%** believed that their service needs were not met by the agency, particularly their need for counseling. On a more positive note, **five** (5) States described early identification of families’ mental health needs, linking families to a wide array of services including family group therapy; **14** States had introduced measures in their PIPs to address the mental health needs of family members,²⁰ twice as many as noted in the Final Reports.

Foster Families

There was some discussion of mental health services and supports needed or provided for foster families. **Four** (4) States noted that more training was needed to assist foster parents in working with children with significant emotional and behavior problems. **One** (1) State described an increased training requirement for foster parent licensure and the provision of

¹⁸ *General Findings from the Federal Child and Family Services Reviews*, p. 27 (See <http://www.acf.hhs.gov/programs/cb/cwmonitoring/results/index.htm>.)

¹⁹ *General Findings from the Federal Child and Family Services Reviews*, p. 13 (See <http://www.acf.hhs.gov/programs/cb/cwmonitoring/results/index.htm>.)

²⁰ See Section 2, p. 40, of this report.

additional training for foster parents who care for children with special emotional and behavioral health needs. **Another** State described placement stability services to assist foster families when crises occur.

Permanency and Stability

Thirty-three (33) State CFSR Final Reports demonstrated that many system challenges coalesced around the goals of permanency and stability for children. The complex behavioral health needs of children, along with the lack of early diagnosis, lack of specialized providers to address needs, and insufficient well-trained and supported foster parents and social workers, led to placement disruptions, instability, and difficulty in establishing and reaching a permanent goal. According to several States, children with emotional and behavioral challenges often were not considered ready for adoption, placement resources were few, and efforts were not made to identify adoptive homes for them. Reunification was limited by the availability of mental health and substance abuse services for parents; reentries of their children into care were attributed to the same services deficits. State Final Reports attributed instability and the lack of permanency to the following:

- Lack of specialized placements for children with severe medical, psychiatric, or substance abuse needs (**11 States**)
- Few adoption resources for older children with behavioral challenges (**7 States**)
- Inadequate training and support for foster parents who care for children with serious emotional disorders (**7 States**)
- Parental mental health needs (and lack of services) that hindered achieving and sustaining reunification (**6 States**)
- Lack of permanent plans and effective transitional services for older youth with mental health and behavioral issues (**5 States**)
- Parental substance use problems (and lack of services) that hindered achieving and sustaining reunification (**4 States**)
- General attribution of instability and lack of permanency to the child's behavioral problems (**4 States**)
- Lack of specialized placements for children in their own communities (**2 States**)
- Placements that did not match child needs (**2 States**)
- Need for more mental health counseling to keep children in their own homes (**1 State**)

ADMINISTRATION AND MANAGEMENT TRENDS

Administrative and management issues surfaced throughout our review of the Final Reports. We have grouped the issues within the trends described below. Trends are listed in the order of those mentioned most often to those mentioned least often.

Coordination and Collaboration

Several trends related to coordination and collaboration around mental health issues were depicted in 38 State Final Reports:

- Although collaboration occurred in many States, it continued to be a challenge.
- Strong State-level collaboration did not necessarily ensure collaboration and service coordination at the local level.
- Certain barriers to collaboration continued to exist.
- In spite of these barriers, some States' strategies to strengthen cross-system collaboration had achieved positive results.

Signs of Strong Cross-System Collaboration Existed and Challenges Remained

Most State CFSR Final Reports (38) described efforts of child welfare agencies to collaborate with other child-serving systems at both the system level (around management issues) and the individual child and family level (around service coordination). In spite of the extent, significance, and value of such system level collaborative efforts, many of the same States found successful service coordination to be difficult, and problems persisted in accessing certain services. The Final Reports demonstrated that although promising, these efforts (e.g., collaborative and interagency teams, special initiatives, shared funding, Memoranda of Agreement) were not enough to resolve ongoing service coordination issues. The Reports emphasized how important it is for collaboration to be an ongoing process to resolve problems and issues as they arise.

For example, **one** (1) State had several promising initiatives under way to improve and expand service coordination; however, the impact of these initiatives had not been enough to allay concerns about historical and ongoing coordination issues among social services, mental health, mental retardation, and the school systems that negatively affected families' access to services. In **another** State, even though mental health, child welfare, and substance abuse agencies engaged in joint treatment planning with all parties, considerable communication barriers existed among these same agencies.

Impact of State Level Collaboration Varied

Six (6) CFSR Final Reports that described strong cross-system collaboration at the State level also portrayed the difficulties in ensuring the same level of collaboration at the local and county levels for a number of possible reasons: the autonomy/ independence of county departments, a lack of involvement of the counties in the State-level collaboration, a lack of

integration and consistency in approaches to the work across agencies, the challenges of getting local child welfare and mental health agencies to work together, and the inability of social workers to follow through because of high caseloads. Another State indicated that systemic issues among agencies at the State level created barriers for families trying to access services at the local level.

Barriers to Collaboration Existed

Additional barriers to collaboration were cited by **eight (8)** States in the Final Reports:

- Children’s mental health services were delivered by multiple agencies and providers, and it was challenging to coordinate them.
- Child welfare and mental health agencies were administered differently, one at the State level and the other at the county level.
- State-level collaborative efforts did not include all relevant stakeholders.
- Leadership positions experienced personnel turnover.
- Different funding sources, different structures, and different mandates for child welfare, mental health, and alcohol and drug services existed.
- The relationships between agencies were complex and problematic.
- Agencies concerned with mental retardation/developmental disabilities did not always cooperate.
- The relationship between local human service agencies and the mental health authority was weak.
- The child welfare agency’s own units lacked internal coordination.

Collaborative Strategies Existed

Although barriers existed, the CFSR Final Reports described many strategies for collaboration and service coordination:

- Interagency teams and task forces (**23 States**)
- Collaborative efforts to build the service array and increase service capacity (**9 States**)
- Regular interagency meetings (**8 States**)
- Policy development and implementation (**8 States**)
- Prevention of unnecessary custody relinquishment by parents to obtain mental health treatment services (**6 States**)
- Efforts to offer a single plan of care for each child and family (**3 States**)
- Co-location of staff (**2 States**)

Accomplishments resulting from each of these collaborative strategies are identified below:

- *Interagency Teams and Task Forces*

Twenty-three (23) States reported that child welfare, mental health, and other agencies were involved in interagency teams that functioned for specific purposes (e.g., multidisciplinary child protection teams and multidisciplinary teams to coordinate services; treatment teams; child and family teams to ensure individualized service plans; State interagency teams to oversee development of systems of care; early intervention teams; mental health collaboratives; policymaking teams; teams to implement community-based initiatives; care coordination units; stakeholder groups to develop recommendations about system reform; teams to arrange services for children with the most serious mental health needs).

These teams were described as productive, with results and achievements such as these:

- Development of resources
- Increased support from Medicaid for children needing more than acute care hospitalization
- Statewide system redesign
- Creation of integrated care coordination units
- Review of reports of abuse of children in out-of-home care
- Coordinated child welfare and mental health service delivery
- Timely mental health assessments of children entering foster care
- Adoption of systems of care to meet the more challenging behaviors of children and youth in state custody

- *Collaborative Efforts to Build the Service Array and Increase Service Capacity*

The Final Reports of **nine (9)** States described a number of services that were developed or expanded through interagency collaboration:

- Statewide implementation of the wraparound process
- New residential service models to permit children and youth without community placements to leave psychiatric settings when ready for discharge
- Programs for children with assaultive behavior
- Medicaid reimbursement for provider travel in order to serve rural areas
- Behavioral health services
- Mental health services specifically for children in foster care

- *Regular Interagency Meetings*

Eight (8) States described regular ongoing meetings (some monthly, some weekly) among mental health, social services, and Medicaid agencies to address waiting lists, discuss clinically complex child/family cases, plan for services for families served by several agencies, address mental health services for children and youth in custody, and develop policies and guidelines for serving children with significant mental health needs.

- *Policy Development and Implementation*

Memoranda of Understanding and Memoranda of Agreement (MOUs and MOAs) were the primary policy strategies used by **eight (8)** States to develop, coordinate, and implement policies to ensure mental health services for children and families in the child welfare system. **One (1)** State issued Management Practice Standards recommending that county agencies establish agreements and protocols with all major service systems. In **another** State, the children's services department entered into annual contracts with regional community service agencies.

MOUs and MOAs addressed such issues as each agency's area of responsibility and accountability; how services were to be coordinated and delivered across agencies; delivery of services to children and families with special mental health and social service needs; and how services for children in State custody were obtained from the managed care organization.

- *Prevention of Unnecessary Custody Relinquishment by Parents to Obtain Mental Health Treatment Services*

Three (3) States described an increase in the use of out-of-home care that could be due to the lack of community-based mental health resources, causing children to enter the child welfare system in order to access needed care. **Eight (8)** States mentioned the following strategies and initiatives to reduce this practice:

- Conducting review hearings for children who were voluntarily placed by their parents solely because of developmental disability, severe emotional disorders, or delinquency (**2 States**)
- Enacting legislation to prohibit taking children into custody solely for the purpose of giving the access to mental health services (**1 State**)
- Enacting legislation requiring social services, mental health, and juvenile justice agencies to work together in a “system of care” concept to meet the needs of children in, and at risk of, residential treatment, including children who might require out-of-home care to get their mental health needs met (**1 State**)
- Funding community collaborations to prevent inappropriate out-of-home placement in foster care, juvenile justice, and State hospitals (**1 State**)
- Holding workgroup meetings to identify service gaps, funding stream barriers, and other policy and practice issues to find a solution to the custody relinquishment issues (**2 States**)
- Building a comprehensive children's mental health system with a goal of diverting children from State custody who need mental health services but are not at risk of abuse or neglect by their caretakers (**1 State**)

- *Efforts to offer a Single Plan of Care for Each Child and Family (3 States)*

Three (3) States described efforts to create a single plan of care for children and families who were involved with multiple agencies. Child welfare, mental health, juvenile justice, and education agencies and private providers were involved in implementing single plans of care. In **another** State, four regions implemented the single plan of care. **One (1)** State credited interagency collaboration as one of the primary reasons for the agency's effectiveness in being able to individualize services and increase placement stability for children in foster homes. In **another** State, however, the Final Report indicated that mental health providers often had no knowledge of the child welfare "case plan," thus reducing the effectiveness of the case plan because services were not coordinated.

- *Co-location of Staff*

Two (2) State Final Reports described housing mental health therapists and nurses in the child welfare agency. In **one (1)** State, mental health therapists were co-located in social services offices in 12 counties to provide family preservation and reunification services. Children involved with the child welfare system in these 12 counties had better access to mental health services than children in other counties where overloaded community mental health centers were not as timely in their response. In **another** State, the child welfare agency contracted with the Department of Health to provide registered nurses and health program representatives to work in child welfare agencies to manage the physical, dental, and mental health needs of all children entering foster care.

Training

Twenty-six (26) State CFSR Final Reports identified training as a major part of their plans to prepare staff, providers, and parents (foster, adoptive, kin, and birth) to meet the mental health needs of children and families in the child welfare system. Cross-system training with law enforcement, mental health, primary health providers, school counselors and the courts was reported. **One (1)** State reported training professionals from these agencies with foster and adoptive parents.

Eleven (11) States recognized and reported the following range of training needs:

- Specialized training annually for therapeutic foster care providers (40 hours)
- Mental health and substance use training for staff working with adolescents with behavioral health issues
- Training in infant mental health
- Additional training for specialized service units such as mental health assessment and treatment and sexual abuse treatment
- Ongoing training for staff on substance abuse issues and dynamics, child management, discipline methods, conflict resolution, sexual abuse, medications for children (effect of

psychotropic drugs), mental health issues (including how to read psychological evaluations and recognition of underlying mental health needs)

- Training for foster parents on grief and loss; independent living preparation; care of children with behavioral, emotional, and mental health issues; sexual abuse; and access to local services

Two (2) States identified barriers to training for parents, such as lack of transportation and child care.

Funding

Funding issues mentioned in Final Reports focused on the three trends described below:

- Impact of Budget Deficits
- Managed Care
- Creative Funding Strategies

Impact of Budget Deficits (11 States)

Eleven (11) States reported that the then-current economic climate and State budget deficits reduced the availability of mental health services. Several measures to cut costs and address budget deficits were described:

- A narrowing of the population of children who could access services to those with a diagnosis of serious emotional disturbance or those who were overtly acting out (thus, not funding mental health services for children who were moderately unstable)
- Reduction in community contracts
- Reduced ability to support interagency initiatives
- Longer waiting lists and shortened treatment sessions
- Limited funds for psychological exams
- Limited funding for services for children who lived with unlicensed relative caregivers and whose parental rights had not been terminated
- No reimbursement for mental health providers for participation in court hearings, case staffings, or multidisciplinary team meetings
- Decreased availability of mental health services
- Low reimbursement rates for Medicaid providers²¹
- Limits on the types of services that can be reimbursed by Medicaid.

Although most budget-cutting measures had a negative impact on access to mental health services, **one (1)** State reported that budget cuts and a lack of Medicaid providers led some mental health agencies to serve children in foster care on a pro bono basis. Also, a Final

²¹See the section Provider Issues for further discussion.

Report from **one** (1) State indicated that the legislature required the public mental health system to serve both children at risk and children diagnosed as emotionally disturbed.

Managed Care (8 States)

Final reports that mentioned managed care generally were not positive. **Six** (6) States indicated that managed care had created one or more of the following problems:

- Limited the number of therapy sessions
- Restricted treatment
- Eliminated coverage of preventive services
- Eroded the broad service array
- Presented problems in obtaining services for family members (e.g., substance abuse services)

Two (2) States reported positive perspectives on managed care. **One** (1) State that included children's mental health care in a managed care waiver required primary care physicians to incorporate child mental health and substance abuse screening for all children and youth (birth to age 20) in Early and Periodic Screening Diagnosis and Treatment exams. **Another** State reported implementing a managed care initiative in a large urban county that included a plan for integrated physical and mental health care for all children in foster care. If this initiative is successful, it may be expanded Statewide.

Creative Funding Strategies (10 States)

States described a number of funding strategies to strengthen mental health services for children and their families:

- Expanded coverage for children of parents without health insurance through the State Child Health Insurance Program (SCHIP).
- Flexible funding to obtain individualized mental health. **One** (1) State used post-legalization funds (maximum \$2,000/year) to assist adoptive families with acute needs.
- Integration of financial resources across departments and child-serving agencies to develop systems of care in local communities for children with serious mental health needs. **One** (1) State described creating a State-level funding pool, with allocations for each county and city that included Social Service Block Grant funds; State foster care monies; and funds from juvenile justice, education, mental health, and an interagency consortium. In contrast, **one** (1) State noted that having different funding sources (e.g., Title IV-E, Medicaid) for different child-serving agencies created barriers to coordination and collaboration.

Additional funding sources described by **two** (2) States were local funds to pay therapists and Victims of Crime funding for treatment services for children who had been abused, neglected, or victims of domestic violence.

Providers

CFSR Final Reports described a widespread shortage of mental health providers skilled in treating the special issues presented by children and youth who had experienced the trauma associated with abuse, neglect, sexual abuse, multiple out-of-home placements, parental substance use, and domestic violence. **Thirteen (13)** States indicated that problems with Medicaid contributed to the lack of providers available to assess and treat children in the child welfare system. These problems caused some providers to refuse Medicaid reimbursement and also restricted payment to other providers willing to participate in the Medicaid program. Contributing factors follow:

- Low Medicaid reimbursement rates
- Cumbersome or broken reimbursement processes
- Restrictions on the type of providers who can receive Medicaid reimbursement (e.g., **two (2)** States did not allow psychologists to bill Medicaid)

Four (4) States also noted the high turnover rate among counselors, social workers, and therapists as contributing to the shortage of providers, which presented a major challenge to the provision of services. States reported that they had an insufficient supply of the following practitioners:

- Child psychiatrists (**12 States**)
- Providers who accepted Medicaid (**11 States**)
- Providers trained to address the issues related to child abuse, neglect, and adoption (**9 States**)
- Providers to monitor medication (**6 States**)
- Providers to address issues of sexual abuse, for both youthful offenders and victims (**5 States**)
- Providers with the expertise or desire to serve children (**4 States**)
- Caseworkers with the experience or training to accurately assess the need for mental health services (**3 States**)
- Bilingual providers (**3 States**)
- Psychologists (**2 States**)

Data Collection

Only **10** CFSR Final Reports discussed mental health service data collection; however, by the time States were developing their PIPs, almost half of them (**23 States**) discussed the type of mental health service data they planned to track and the specific monitoring and data collection strategies to be used.²²

From the Final Reports, we learned that **six (6)** States lacked aggregate data to identify the mental health needs of children in the child welfare system. **One (1)** State described

²²See Section 2 of this report, p. 47.

difficulty in obtaining reports on individual children from mental health providers; **another** State indicated that it did not know how many children transition from the foster care system into the adult mental health system; and **another** reported that data for mental health and juvenile justice cases lacked accuracy, timeliness, and accessibility.

One (1) State indicated that it will be able to collect more data on children's mental health needs and services once its FACIS system is implemented statewide. It will track mental health treatment, psychological and psychiatric evaluations, and diagnoses. **Another** State described using a child health passport to record mental health information.

Very few of the Final Reports explained how tracked data had been or will be used for program implementation, monitoring, and improvement efforts; however, **two** (2) States described how they used mental health, family, and substance abuse assessment data to evaluate, diagnose, and prescribe services for children. **One** (1) State described the efforts of child-serving agencies and a State university to study various quality assurance issues to enhance data collection.

SECTION 2

Trends in Program Improvement Plans

SECTION 2 is based on an analysis of the 52 Program Improvement Plans (PIPs). It describes strategies related to the following issues:

Inclusion of Mental Health Issues in PIPs

Comprehensive Strategies to Develop Mental Health Service Systems

Trends in Service Delivery:

- Assessment of child and family mental health needs
- Identification of gaps in and building of mental health service capacity
- Service planning for children and families
- Family involvement in planning and delivery of services
- Services for families
- Permanency and stability

Administrative and Management Trends:

- Collaborative efforts
- Systems of care replication
- Training
- Funding
- Providers
- Policy development and implementation
- Tracking and monitoring services received and child and family outcomes

INCLUSION OF MENTAL HEALTH ISSUES IN PIPs

This section describes a number of trends that emerged from the PIPs and the strategies that States were pursuing to better address the mental health needs of children and families. In addition to summarizing mental health related trends in the 52 PIPs reviewed, we sought answers to the following six questions:

1. **Are *mental health issues* mentioned in the PIP?**
 - All 52 (100%) PIPs included a discussion of mental health issues.
2. **If mental health issues are mentioned, do the goals of the PIP address the mental health issues?**
 - Almost all the PIPs (88%) included goals related to mental health issues. One PIP did not, and inclusion could not be determined in five PIPs.
3. **If mental health issues are mentioned, are there related *action steps*?**
 - Almost all the PIPs (94%) included action steps related to mental health issues, including **three (3)** States without specific mental health goals.
4. **Are *mental health stakeholders* listed as PIP team members or obviously involved in the action steps?**
 - To determine whether mental health stakeholders were involved in addressing the mental health issues, we reviewed the lists of PIP team members in each State and the assignment of leadership regarding specific steps in the PIP. It was difficult to obtain a complete picture of PIP team representation because

half of the PIPs (50%) did not clearly identify team members; however, 48% of the PIPs did include mental health stakeholders. This figure includes two States that acquired input from mental health stakeholders in the development of the PIP through participation in external workgroups and special forums.

5. Are *parents* listed as PIP team members?

- As in question 4, it was difficult to form a valid answer to this question because many of the PIPs did not clearly identify team members. The analysis did show that 14 States (27%) were involving or planned to involve family members in the PIPs, including one State who held community forums to obtain input from families and community stakeholders. Ten (10) States (19%) were not. We could not determine the role of parents in the other 54% of States.

6. Does the State identify in its PIP a need for technical assistance regarding mental health issues?

- Even though every State mentioned mental health issues in its PIP, only 15 States (29%) clearly indicated that they needed or will request technical assistance to address mental health issues and needs. The majority (10) of these States were among the last to complete their PIPs. This is not surprising, given that the PIPs that were submitted later tended to be more comprehensive in their discussion of mental health issues, services, and needs. However, the majority of States (65%) did not express the need or desire for technical assistance around mental health issues.

COMPREHENSIVE STRATEGIES TO IMPROVE MENTAL HEALTH SERVICES

Our review of the 52 Program Improvement Plans revealed many strategies to ameliorate the problems described in the Final Reports. Whereas approximately half the PIPs included one or two action steps related to mental health issues, 24 were taking a more comprehensive approach. When a PIP described three or more statewide strategies or action steps that focused on improving mental health services, we categorized this as being comprehensive. These 24 States were engaged in many of the strategies that are described in the trends in Section 2:

- Screening and assessing children and their families
- Conducting a community and/or statewide needs assessment to determine gaps in or barriers to mental health service availability
- Building and expanding the service array and availability

Missouri's Comprehensive Children's Mental Health Initiative has been identified as a best practice by the Administration for Children and Families. This initiative offers an organized, comprehensive, and seamless system that will enable children with complex mental health needs to remain in their homes, schools, and communities and receive the mental health services needed. This system will provide mental health services that are easily accessible, culturally competent, and flexible to individual needs and that result in positive outcomes for the children and families it serves. The initiative is a collaborative effort to develop statewide and local resources and remove barriers for children with special needs. It is made up of agencies that provide services to individuals at the State and local levels and also includes parents and parent-run organizations.

(<http://www.dmh.missouri.gov/diroffice/depdir/childsvcs/ChildrenInitiative.htm>)

- Making services for children and families in the child welfare system a priority of the mental health system
- Engaging in cross-system collaboration, including sharing information and data across systems
- Broadening the representation in workgroups and in the PIP planning process
- Implementing financing strategies to develop and expand services, such as pooling funds across systems, expanding Medicaid eligibility, requesting additional funds from the legislature, and providing flexible funding to pay for nontraditional services
- Implementing better documentation and monitoring of mental health needs and follow-up services to ensure that services are provided
- Developing mental health practice guidelines
- Enhancing training for social workers, foster parents, and clinicians
- Inventorying and disseminating information on the availability and effectiveness of services and providers
- Developing, implementing, and replicating successful procedures to recruit mental health providers
- Implementing the prevention of custody relinquishment strategies
- Planning and implementing a statewide comprehensive children's mental health system to provide services to children with serious mental health concerns without bringing them into out-of-home placement or residential care

Rhode Island's Department of Children, Youth and Families (DCYF) is developing the Integrated Family and Community System of Care (FCSC) initiative by consolidating six (6) current DCYF programs into the functions of one or more Family Care Coordinating Programs (FCCPs). The reorganization is designed to provide more timely access to family preservation services to children at risk of abuse and neglect and a broader range of community supports for families with children who suffer from serious emotional disturbances.

DCYF saw a greater necessity to strengthen the front-end of its service delivery system in order to divert families from coming into care or higher levels of care as much as possible. It also recognized the need to ensure services to families sooner rather than later in order to prevent them from reentering the Department with more serious issues.

The Family and Community System of Care (FCSC) will be a "wraparound" model of service planning and delivery that will include flexible wraparound funds and a family-centered method for purchasing family support services and interventions. In FCSC, all funds and services will follow the child and family and result in increased community integration and greater care coordination.

(<http://www.dcyf.state.ri.us/>)

TRENDS IN SERVICE DELIVERY

Assessment of Child and Family Mental Health Needs

As mentioned in Section 1, 18 State CFSR Final Reports described problems that occurred when mental health screening and assessments were not conducted. Twice as many States (36) identified strategies for improving the assessment of child and family mental health needs. Strategies proposed by multiple States follow:

- Developing, reviewing, and implementing screening and/or assessment tools (19 States)
- Strengthening existing comprehensive family assessment processes to include the assessment of child and family mental health needs (12 States)

- Increasing the number of children entering foster care who receive mental health assessments (12 States)
- Developing pilot projects to conduct mental health screening and assessment of all children in the child welfare system, before moving to a statewide system (5 States)
- Setting specific standards for assessing and meeting the mental health needs of children in child welfare (4 States)
- Documenting behavioral health assessment results in electronic records or in the child's case plan (3 States)
- Using the Early and Periodic Screening, Diagnosis and Treatment program to strengthen mental health screening for children in child welfare (2 States)

In addition to the strategies above, each of the following strategies was proposed in at least one (1) State's PIP:

- Creating a tool to help foster parents and child welfare staff identify behaviors that indicate a child may need a comprehensive evaluation
- Screening for the mental health needs of children in need of services (CHINS) and youth who have been adjudicated
- Requesting funding from the state legislature to increase behavioral health assessments of children entering care statewide
- Distributing information about assessment tools to local mental health providers
- Creating diagnostic congregate care stabilization centers to diagnose and assess the needs of older youth who have issues with family living situations
- Initiating a comprehensive approach to assessment that included technical assistance and training, policy changes, changes in the State information system, certification of staff, and evaluation of the effort.

Screening and assessing the mental health needs of children in the child welfare system is often a two-step process. An initial and immediate mental health screen is used to identify problems that require immediate attention and/or further evaluation. A comprehensive mental health assessment is more extensive and addresses a child's mental/emotional and developmental strengths and needs. It focuses on the child, the family, and the environment in which they live. Most of the PIPs that mentioned screening and assessment did not acknowledge that it is a two-step process with different timeframes and purposes. Thus, it is not clear whether the strategies described related to screening, to a more comprehensive assessment, or to both.

Identification of Service Gaps and Building Service Array and Service Capacity

Consistent with the deficits in the service array noted in the Final Reports, 21 States proposed to develop all, or some combination, of the following services:

- Addiction services
- Therapeutic foster care
- Treatment for youth who had been sexually abused and services for sexual offenders
- Intensive in-home, community-based services
- Behavioral health services for children and youth in foster care

In their PIPs, 37 States described multiple strategies to build their service array and increase their service capacity.

Fourteen (14) States were aggregating the findings from the assessment of individual child and family mental health needs to identify the array of services needed by children in foster care and in their own homes.

Sixteen (16) States were implementing a statewide needs assessment or resource inventory to identify service strengths and service gaps. These States planned to create resource development plans and/or explore potential funding sources for an expanded array of services. States proposed strategic ways to use the data from their statewide needs assessments:

- Supporting legislative requests
- Marketing a family drug court
- Gaining the advocacy of a children's cabinet
- Negotiating with Medicaid or mental health authorities
- Modifying procurement regulations
- Supporting demonstration/pilot programs
- Justifying in-home services for children in child protective services
- Supporting the hiring of mental health therapists to facilitate earlier discharge planning from in-patient facilities
- Supporting a plan for foster parent recruitment and support

Eight (8) States proposed to expand the continuum of mental health services through Medicaid and managed care strategies. The Medicaid strategies included expanding the types of services reimbursed by Medicaid and monitoring and appealing Medicaid denials of mental health claims. **Two (2)** of these States were negotiating with managed care plans to enhance service capacity and to pilot a managed care program to integrate mental, physical, and dental health care for all children in foster care. Findings from this pilot will influence recommendations for the balance of these States' actions.

Five (5) States described strategies to support access to existing services, including preparing resource directories designating a mental health contact to assist child welfare staff in accessing available resources and reviewing children in higher levels of out-of-home care in order to move them to less restrictive care when appropriate.

In an effort to promote placement stability, **three (3)** States described plans to provide foster family support services, professional foster homes for adolescents experiencing placement instability, 24-hour mobile response and crisis stabilization, and foster homes for medically fragile children. States also described policies to support the recruitment and retention of foster parents, including pre-adoptive homes. Many of these services will be developed through interagency collaborations.

Three (3) State PIPs discussed one or more of the following strategies for expanding the availability of evidence-based practices for children in the child welfare system:

- Developing a competent workforce trained in evidence-based practices
- Creating a state-level institute to conduct research and to develop and implement evidence-based interventions for children who suffered sexual abuse, physical abuse, exposure to domestic violence, and other trauma
- Using Medicaid funding to increase the availability and accessibility of evidence-based community and in-home services

Two (2) States proposed a specialized services continuum that includes services such as early intervention services, intensive home-based services, multi-systemic therapy (MST), family therapy, substance abuse treatment, mobile crisis services, transportation and visitation, and supported housing for families with behavioral health needs.

In addition, **one or more** States described plans to create or expand the following services:

- Outpatient services
- Clinical in-home services
- School based mental health services
- Targeted case management
- Early childhood mental health services
- Services for youth who are sexually reactive or aggressive
- Adoption competent mental health services
- Wraparound teams
- Psychological evaluations
- Behavioral assistants

Two (2) States did not address their acknowledged services deficit by proposing new services.

Service Planning for Children and Families

Eleven (11) State PIPs described efforts to improve one or more of the following individual and family-level service planning processes:

- Implementing the wraparound process in child welfare and combining the child welfare system efforts with the mental health system wraparound process so that wraparound becomes the case management model for the child welfare system, with the ultimate goal of implementing a single plan of care for each child that will support the wraparound process
- Implementing a care management system to coordinate child and family care across systems
- Using formalized assessment protocols for systematic determination and monitoring of child and family mental health service needs
- Adopting a family-centered approach to increase the involvement of children, families, foster families, and community stakeholders in the case-planning process
- Implementing solution-focused and strength-based case management models to preserve community connections and the continuity of familial relationships
- Increasing the number of case managers who coordinate behavioral health care services, and expanding their role and population of focus
- Using culturally competent service planning processes, including assessment and consideration of cultural heritage and connections in case planning
- Providing training and technical assistance for staff and local agencies on case planning

Family Involvement in the Planning and Delivery of Services

Only six (6) of the 52 State PIPs highlighted strategies for improving family involvement in the planning and delivery of mental health services. For three (3) of these States, efforts to improve family involvement were specifically aligned with the adoption of wraparound models, systems of care models, and/or the principles of family-centered, strength-based practice that are inherent to these models, including full participation on wraparound teams and involvement in the needs assessment and case management processes.

Several of these six (6) States proposed one or more additional strategies for increasing the number of supports, opportunities, and oversight vehicles necessary to improve family involvement in service delivery and planning:

- Instituting a standardized case management model that is driven by the family
- Increasing opportunities for shared family experiences and activities within therapeutic foster care agencies
- Using a comprehensive family assessment and family-centered service plan across child welfare divisions that builds on family strengths and encourages full participation from families
- Creating opportunities for families to discuss mental health needs of the child and family and/or to meet with family therapists and other service providers at bimonthly family team meetings

Services for Families

Fourteen (14) States introduced measures to address the mental health needs of other family members and caregivers in an effort to support placement stability and reunification of children and youth involved with the child welfare system. These efforts primarily included the following activities:

- Developing new services
- Linking to adult mental health systems for the provision of outpatient services, partial hospitalization, case management, and medication services to special populations
- Adopting treatment models that include comprehensive supports to all family members

Seven (7) States were developing additional mental health services and supports for birth families, including populations with special needs, such as adults with severe mental illness; parents for whom reunification depends on receiving mental health services; pregnant and parenting women; and families who are entering the child welfare system for the first time.

Six (6) States proposed that the impact of underlying issues, including domestic violence, be addressed, that parental mental health and substance abuse issues be assessed, and/or that staff receive training to recognize and address these issues.

Four (4) States proposed developing intensive, home-based services, including multi-systemic therapy and the wraparound process, which include services for all family members.

Permanency and Stability

A total of only **eight (8)** States discussed the importance of improving mental health services in order to achieve permanency, stability, and reunification. The most commonly proposed and implemented solution for addressing these issues was to strengthen mental health services and supports.

Three (3) States expected to prevent out-of-home placements and preserve the stability of placements through the ongoing provision of mental health services, 24/7 crisis intervention services, care coordination, intensive in-home services, and/or expanded community-based mental health services.

Hawaii's Department of Human Services has proposed to expand its Comprehensive Counseling and Support Services (CCSS) by purchasing services contracts that will provide intensive support to parents. These services will include counseling, parent education, life skills training, outreach, and transportation services.

(Child and Family Service Plan, 2005-9: http://www.hawaii.gov/dhs/protection/social_services/child_welfare/cfs_plan_fy2005_2009)

Illinois has formed a collaboration among its child welfare, human services, and public aid departments to create a single point of entry for foster parents so that they may access crisis and screening services 24 hours a day, including a crisis hotline, to request immediate crisis intervention services and to determine whether a child's emotional/behavioral problems are jeopardizing the stability of the placement. Immediate crisis, short-term services and clinical interventions are subsequently provided to manage potential placement disruptions, increase the successful transition process from more to less restrictive placements, and maintain children in traditional and relative care placements.

(<http://www.hfs.illinois.gov/cmh/hfs3838.html>)

Two (2) States identified the point of entry into the child welfare system as a target for enhancing the availability of mental health services and supports to children and families, including therapeutic reunification supports and mandatory family support team meetings prior to out-of-home placement.

Two (2) States proposed that staff training and development regarding the special mental health needs and concerns of children in foster care may alleviate problems associated with placement disruption and permanency. These activities include training in grief and loss, reactive attachment, and behavioral disorders, as well as encouraging staff to use creative, therapeutic resources to maintain a child in the home, such as mentoring, in-home respite services, or therapeutic recreation.

ADMINISTRATIVE AND MANAGEMENT TRENDS

Collaborative Efforts

The PIPs reflected very closely the extensive list of collaboration and coordination issues mentioned in the Final Reports. In the PIPs, 37 States proposed collaborative strategies to find resolutions to the following issues:

- Eliminating system-level barriers
- Identifying mental health service gaps and increasing the service array and service capacity
- Integrating service plans
- Improving communication
- Prioritizing children and families in the child welfare system as service recipients
- Managing referrals
- Offering cross-system training
- Sharing information and data across systems
- Pooling funds
- Reducing mental health service denials and addressing access to services
- Improving the capacity to provide comprehensive mental health assessments.

Some of the strategies used to address these issues follow:

- Creating community level partnerships to strengthen and integrate services at the community level (e.g., a network of community hubs that provide a base of operation for cross-system services).

- Implementing State-level cross-system governing bodies and task forces. In several States, the child welfare system participated in a statewide children’s mental health partnership to strengthen the system and to develop a comprehensive State children’s mental health plan.
- Implementing cross-system Memoranda of Agreement.
- Restructuring State agencies to consolidate services for children (across systems) and achieve better service coordination (2 states).
- Integrating funding across child-serving systems.

Twenty-five (25) States noted the involvement of mental health representatives on the PIP team or in workgroups. Several of those States described mental health in a leadership role on specific aspects of the PIP.

Systems of Care Replication

Twenty (20) States described efforts to coordinate services across systems, develop integrated interagency policy ensuring access to appropriate treatment, and oversee the development and implementation of community-based mental health systems of care for children and families. These efforts included the formation of interagency teams and task forces.

In 2007, there were **57** active systems of care in **32** States and **two (2)** territories funded by the Federal Center for Mental Health Services and **nine (9)** system of care grants funded by the Children’s Bureau in the Administration for Children and Families. At the time of the analyses of the PIPs, we found that **16** States were expanding the system of care values and framework to obtain a seamless statewide cross-agency mental health system to improve outcomes for children and families in child welfare.

The Dawn Project System of Care of Marion County, Indiana, has been identified as a best practice by the Administration for Children and Families. This system of care serves children with serious emotional disturbances who have been separated, or are at risk of separation, from their families. The program has been recognized for its use of creative funding and accountability structures.

(<http://www.kidwrap.org/page/program/alias/dawn&article=311&prog=311>)

Iowa offers an example of collaboration at the state and community level in its Community Partnerships for Protecting Children (CPPC). This approach for keeping children safe from abuse and neglect and supporting families recognizes that keeping children safe is everybody’s business. It offers community members opportunities to provide input into design and governance, and to participate in programs that seek to create a continuum of care and support for children, youth, and parents in their own neighborhoods.

Each CPPC organizes a network of neighborhood and community supports and creates a network of agencies, neighborhood groups, and families to support the overall mission of community child protection. Core members of networks include schools, faith institutions, mental health professionals and healthcare providers, substance abuse and domestic violence programs, police, childcare providers, parent groups, and the public Child Protective Services (CPS) agency. Some CPPC sites have developed community “hubs”—places that provide the base of operations for partnership-related activities in the area. Often CPS staff who are linked with these hubs are easily accessible to families, work closely with other service providers, and learn more about the unique characteristics of the community in which they work.

(<http://www.dhs.state.ia.us/cppc/index.html>)

Fifteen (15) of these States were already engaged in extensive collaboration and partnering across systems in the interest of meeting the mental health needs of children in child welfare. Examples of their efforts follow:

- **Six (6)** States had already begun to develop and coordinate financial resources across child-serving agencies to develop systems of care for children with serious mental health needs. **One (1)** of these States blended funding and programmatic resources to integrate crisis services, intensive clinical interventions, and strength-based case planning for foster families and children.
- **Two (2)** States described plans to develop or expand statewide wraparound processes as part of their system of care.
- **One (1)** State was designing long-term goals to focus on designing a seamless multi-system response to its self-described “overwhelming need for mental health services for children in the State’s care.”
- **One (1)** State entered into collaboration with health, justice, probation, education, welfare, developmental disabilities, and child welfare (State Commission) agencies to ensure that the children and families in the State child welfare system receive appropriate priority for services across systems.
- **One (1)** State’s Department of Child and Family Services submitted a joint proposal along with the Department of Education to expand community-based supports for children and youth in schools implementing evidence-based, comprehensive school mental health services.
- **One (1)** State indicated that it had a goal of developing a system of care for children with mental health needs and their families.
- **One (1)** State planned to use existing system of care managers to focus on developing, maintaining, and evaluating its local and regional systems of care.

Training

Training was a frequently proposed strategy in the PIPs for addressing mental health issues. **Thirty-nine (39)** States proposed to train child welfare staff, mental health clinicians, foster parents, adoptive parents, and/or private agency partners on a variety of topics:

- Screening and assessment protocols
- Mental health practice guidelines
- Preparation of clinicians to diagnose children younger than 3 years of age
- Service planning
- The wraparound process
- System of care principles
- Medicaid eligibility
- Access to crisis and continuing mental health services
- Attachment and trauma issues
- The impact of sexual abuse
- Recognition of underlying issues such as substance abuse, mental illness, and domestic violence that have an impact on a child’s mental health, safety, and risk of harm

The training topic cited most often in the PIPs was screening and assessment for mental health needs. This demonstrated how States are supporting the implementation of the screening and assessment tools and protocols mentioned earlier in this report.

Eleven (11) States proposed training foster parents on several behavioral health issues:

- Managing challenging behaviors
- Using medical passports to document medical and mental health information
- Dealing with grief and loss
- Dealing with sexual abuse
- Accessing mental health services and challenging questionable recommendations

To institutionalize their training programs, several States described partnering with schools of social work (**3 States**) and developing statewide child welfare training academies (**4 States**). **One (1)** of these States created an Assistant Commissioner for Training to lead the training effort. This same State instituted a Certificate in Adoption Practice for adoption staff and providers to strengthen their skills to support families who adopt older children and children who have emotional and behavioral health needs.

To have statewide impact, Mississippi has created a Child Welfare Training Institute (CWTI) at the University of Southern Mississippi that is supported by a consortium of social work programs from six universities around the State. The CWTI is funded by the Mississippi Department of Human Services with Federal funding.

Mississippi's PIP indicates that the Child Welfare Training Institute will offer ongoing specialized trainings for social workers and supervisors in areas such as substance abuse, domestic violence, mental health/illness, and working with the courts.

Mississippi also plans to develop ongoing training and a practice guide in assessment, case planning, and family/community engagement that will address mental health needs and partnering with the mental health care providers.

(<http://www.usm.edu/pr/prnews/aug05/title4e.htm>)

Funding

In Section 1, Trends in Final Reports, we noted budget deficits and managed care as two funding trends that had a negative impact on the availability of services. The Final Reports also discussed some creative funding strategies implemented by **five (5)** States. **Nine (9)** State PIPs, especially those PIPs most recently completed, described how funding strategies could be used to achieve various objectives:

- Improving access to community-based behavioral health care
- Increasing the number of clinicians providing targeted case management and outpatient services
- Providing care coordination
- Providing individualized care
- Expanding the infant mental health team model
- Providing in-service training for foster parents and support for local foster parent associations

To achieve these objectives, strategic collaboration across child-serving systems, with managed care plans, and with Medicaid was required. One or more of these **nine (9)** PIPs described the following financing strategies:

- Redirecting funds from residential care to community-based services
- Leveraging Medicaid funds to enhance flexibility in service delivery
- Redesigning the state’s Medicaid behavioral health plan
- Integrating cross-system funds
- Targeting funding sources to address gaps in mental health services
- Expanding the number of children eligible for services and targeting children in the child welfare system
- Obtaining additional budgetary support from the state legislature
- Applying for foundation funding
- Implementing a process for frontline workers to access flexible funds
- Providing a funding grid for staff as a quick reference on how various funding streams can be used
- Working with the statewide managed care organization

The Rhode Island PIP includes multiple financing strategies to achieve the State’s objectives and support the Department of Children, Youth, and Families (DCYF) redesign efforts.

1. An Inter-departmental Managers Group, chaired by a DCYF Assistant Director, meets bimonthly to focus on Children’s Behavioral Health and Education systems reform. This group has addressed the effect of cross-system budget deficits, the rising cost of psychiatric hospitalizations, and access to Medicaid funds and services.
2. Rhode Island has enrolled all children in foster care into Medicaid managed care and is working closely with the statewide health plan and its behavioral health provider to improve access to medical and behavioral health care for children in substitute care.
3. Rhode Island has competed for and received grants such as the SAMHSA Coordinated System of Care grants for children. Recently DCYF and the Department of Education jointly applied for grant funding to enhance community supports for children and youth.
4. At the community level, Rhode Island has enabled care management teams to authorize specialized services and funded the “Enhanced CASSP” program, a community-based system to provide individualized supports and services for children with serious emotional disturbances.
5. Rhode Island has integrated education funds, community mental health block grant funds, and DCYF funds and is considering optimization of all funds, including State general funds and Federal funding resources, to ensure better delivery and coordination of services across State departments.

(For Integrated Family and Community System of Care for Rhode Island Concept Paper and Answers to FAQs: http://www.dcyf.ri.gov/docs/dcyf_draft_concept_paper.pdf and http://www.dcyf.ri.gov/docs/aso_faqs.pdf)

Providers

The Final Reports and PIPs clearly identified a shortage of mental health providers experienced and skilled in treating the special issues presented by children and families involved with child welfare. A significant contributing factor to the provider shortage was the lack of providers who participated in the Medicaid program. Given the significance of this problem, we expected to find multiple strategies in the PIPs for addressing it. Instead, only a few states described strategies for recruiting mental health providers. **Four (4)** States discussed efforts to work with their Medicaid divisions to reduce the administrative burden on Medicaid providers and to recruit new providers. **Two (2)** States opened the door to a broader range of Medicaid providers, encouraging traditional child welfare providers to become certified Medicaid providers. **Two (2)** other states used the contracting process to provide incentives for providers to offer certain services. **One (1)** State actively involved providers in identifying the barriers to providing needed services and finding solutions. **One (1)** State had a Federal grant that enabled it to increase the number of adoption-competent mental health providers in the rural areas of the state.

Policy Development and Implementation

Our review of the PIPs revealed that States were developing new policies and revisiting existing policies to improve mental health services for children, youth, and families and to accomplish change at both the service delivery and systems levels. States have enacted policy to implement the strategies described in this report:

- Strengthening the Assessment of Child and Family Mental Health Needs
- Expanding or Creating Mental Health Interventions
- Improving Coordination, Collaboration, and Oversight Within and Across Systems

Strengthening the Assessment of Child and Family Mental Health Needs

Twenty-one (21) States proposed strengthening policy related to the assessment of mental health needs of children and families by using uniform assessment protocols across systems, expanding the population of focus required to receive clinical assessments, modifying assessment tools to include screening for and assessing mental health needs, developing new assessment instruments, and training staff in how to use them.

Expanding or Creating Mental Health Interventions

Thirteen (13) States proposed additional new or revised existing policies related to developing, expanding, and providing mental health services (e.g., instituting family-centered practice; developing policies and protocols for the implementation of evidence-based programs and psychiatric emergency services; revising administrative regulations to ensure that mental health and substance abuse treatment are provided; assessing service array

The Illinois Children's Mental Health Act of 2003 represents a comprehensive policy strategy to coordinate child mental health services statewide, including prevention, early intervention, and intensive treatment services for all children and transition-aged youth. This legislation is intended to increase the availability and accessibility of mental health services to children and families.

(<http://www.hfs.illinois.gov/cmh/930495.html>)

needs and creating resource development plans; developing educational and mental health specialists to serve as regional experts; developing a wraparound certification program).

Improving Coordination, Collaboration, and Oversight Within and Across Systems

State policies were also geared toward improving the processes of coordination, collaboration, and oversight within and across systems, as well as addressing the processes necessary to achieve policy change. Examples are illustrated below.

Six (6) States proposed collaboration across systems to coordinate policies and develop uniform intake and referral between child welfare and mental health agencies. **Two (2)** other States proposed implementing a new single point of entry process to improve communication among counselors, caregivers, families, and services providers.

Three (3) States proposed policies to monitor mental health providers or revise procurement regulations and certification guidelines. **Another** State proposed monitoring the use of residential care and contracts.

One (1) State proposed improving policies related to information sharing as a strategy for enhancing the access and availability of substance abuse services for children, youth, and families within the child welfare system.

One (1) State proposed convening both State and regional meetings to revise its entire model of child welfare practice. This process will include identifying family mental health issues and then drafting and circulating policies and revised instructions based on this updated statewide model.

Tracking and Monitoring Services Received and Child and Family Outcomes

Twenty-three (23) PIPs discussed the type of information about mental health services they plan to monitor and track and/or described some specific monitoring and data collection strategies.

Types of Information Tracked

The types of information States are tracking include the following:

- Receipt of mental health assessments
- Receipt of appropriate services in a timely manner (**15 States**)
- Outcomes such as the impact of the provision of mental health services on child and/or family functioning (**5 States**). **Four (4)** States track, monitor, and evaluate the impact of residential care on children who have extraordinary needs
- The match between the level of care provided and the services needed (**4 States**)
- The quality of care received (**3 States**)

Strategies to Track and Monitor

Specific monitoring and data sharing strategies described in the PIPs include the following:

- Documenting in case plans how identified mental health needs are met (7 States; documentation was one of the most frequently proposed strategies in the PIPs)
- Establishing or using existing quality assurance (QA) systems and reports to monitor the timeliness of mental health service delivery, track whether mental health needs are addressed, and monitor the performance of providers (6 States)
- Monitoring compliance with EPSDT requirements (4 States)
- Using supervisory case review instruments to ensure that mental health issues are addressed (4 States)
- Using the case review process (3 States) as a data source for evaluating disparities in mental health service delivery and tracking the extent to which the mental health needs of individual children and families are addressed
- Using Management Information Systems (MIS) for systematic entry of mental health assessment data (2 States)
- Using existing electronic case plan reporting processes (2 States) to document child mental health needs and date of psychological assessment
- Improving standards for purchasing services and developing tools to match services with the level of care needed by each child (2 States)
- Creating a special unit to track the safety, health, and well-being of children in residential treatment (1 State)
- Maintaining on-site monitoring at residential treatment centers (1 State)
- Matching data among child welfare, Medicaid, and mental health payment records
- Using registered nurses employed by the Department of Health to monitor care for children in custody (1 State)
- Establishing standard monthly reporting by providers (1 State)
- Collaborating with a university affiliate to enhance mental health treatment and discharge planning database for children placed in “high end” settings (1 State)

Hawaii developed a method to capture data on children from Child Welfare Services (CWS) who are referred to the Children and Adolescent Mental Health Division (CAMHD) for Support for Emotional and Behavioral Development (SEBD). Quarterly data reports describe the referrals received and eligibility for SEBD. To address the problem of accessing mental health services (e.g., therapeutic group homes, therapeutic foster care), CWS and CAMHD put several other procedures in place:

- Established a protocol for resolving difficulties
- Identified state-level and local-level points of contact (CAMHD staff) to help problem solve
- Committed to quarterly meetings of CWS and CAMHD administrators to resolve systemic problems and expedite the entry of eligible children from child welfare into therapeutic foster homes

(<http://www.hawaii.gov/health/mentalhealth/camhd/library/webs/sebd/sebd.html>)

In Utah, the Department of Human Services and the Department of Health (DOH) teamed together to provide the Fostering Healthy Children Program. This unique and highly effective program ensures the monitoring of health services for children in the custody of the state by Registered Nurses (RN) employed by the DOH. Each child in care has an assigned RN who manages his or her physical, mental, and dental health care. The nurses are co-located in DCFS offices and are an integral part of the service team. They input and track all physical, dental, and mental health information in the SAFE system; coordinate care; and ensure access to health care providers.

(<http://health.utah.gov/cshcn/fhcp>)

SECTION 3

Summary of Continuing Challenges and Opportunities

SECTION 3 summarizes the challenges, opportunities, and reform strategies described throughout previous sections of this analysis. The summary addresses the following trends:

Challenges and Opportunities:

- Mental health assessments and services
- Family involvement
- Services for family members
- Collaboration

Additional Challenges:

- Permanency and stability
- Providers/rural areas
- Funding

Additional Opportunities and Solutions:

- Comprehensive strategies
- Training
- Policy development and implementation
- Tracking and monitoring of services received and child/family outcomes

Our review of the 52 Final Reports and Program Improvement Plans uncovered significant concerns about the status of mental health services for children and families in the child welfare system. These concerns are confirmed in the general findings of the State-level data summarized by the Children’s Bureau on its Web site:²³

- **Fifty-one (51)** States did not achieve substantial conformity with Well-Being Outcome 3—*children receive adequate services to meet their physical and mental health needs.*²⁴
- In **48** States, Item 23—*mental health of the child*—was rated as an area needing improvement. It was rated as a strength in only **four (4)** States.

Although the Final Reports demonstrated the continuing challenges, we found evidence in the PIPs that States were taking the opportunity to address these challenges. The PIPs described a number of solutions that States are working on to adequately meet the mental health needs of children and families. Every PIP mentioned mental health issues, and **46** of them included goals and action steps related to mental health.

²³ *General Findings from the Federal Child and Family Services Reviews* (See <http://www.acf.hhs.gov/programs/cb/cwmonitoring/results/index.htm>.)

²⁴ To achieve substantial conformity in this outcome, a state has to “substantially achieve” the outcome for 90% of the children in the sample of cases reviewed.

CHALLENGES AND OPPORTUNITIES

Mental Health Assessments and Services

Challenges

The State Final Reports described many challenges to providing comprehensive mental health assessments for children in the child welfare system. In some States, even when assessments were conducted, there was no assurance that a child would be referred for or receive recommended follow-up services. States also noted the lack of documentation and coordination of children's mental health care.

States consistently described the lack of appropriate mental health services, with some services more available than others. The following services were most frequently cited as unavailable:

- Specialized behavioral health services for children who have been sexually abused and/or for children who have sexually offended
- Therapeutic foster care
- Substance abuse treatment (for youth and adults)
- Intensive in-home, community-based services

Challenges to receiving services included inadequate transportation, waiting lists, service hours that did not permit night or weekend services, and a lack of a reliable centralized database to track services availability and utilization.

A content analysis conducted by the Children's Bureau on the CFSR Final Reports for the 35 States reviewed in FY 2002-2004²⁵ identified the following similar challenges:

- Lack of mental health services for children (**25 States**) and inconsistency in conducting mental health assessments for children when an assessment was warranted (**24 States**)²⁶
- Mental health assessment and treatment services insufficient to meet children's needs (**31 States**)²⁷
- Scarcity of appropriate placement options for children with developmental disabilities or with severe behavior problems (**19 States**)²⁸

²⁵ *General Findings from the Federal Child and Family Services Review* (See <http://www.acf.hhs.gov/programs/cb/cwmonitoring/results/index.htm>.) Thirty-five States were reviewed between 2002 and 2004; thus, for the ACF Content Analysis, *N* = 35 rather than 52.

²⁶Item 23—mental health of the child

²⁷Item 35 (systemic factor)—availability of services

²⁸Item 6—stability of foster care placement

Opportunities

The majority of State PIPs identified strategies for improving the assessment of child and family mental health needs and for building or expanding the array and accessibility of mental health services. Assessment strategies most frequently proposed:

- Developing or reviewing screening and assessment instruments
- Implementing a common assessment tool used by all child-serving systems
- Strengthening existing comprehensive family assessment processes to include child and family mental health needs
- Increasing the number of children entering foster care who receive mental health assessments

Strategies for identifying service gaps, expanding the service array, and making services accessible to children and families:

- Aggregating the findings from the assessment of individual child and family mental health needs to identify the array of services needed
- Conducting statewide needs assessments to identify service strengths and service gaps
- Implementing strategies to increase access to existing services

States used data from their Statewide service needs assessments to obtain necessary resources, modify regulations, hire mental health therapists, create a resource enhancement plan, and negotiate expanded Medicaid coverage.

Services being developed or expanded by States:

- Addiction services
- Treatment foster care
- Sexual abuse treatment
- Intensive in-home services
- Evidence-based practices
- 24-hour mobile response and crisis services
- Case management
- School-based youth services program
- Behavioral health services targeted for children and youth in foster care

Family Involvement

Challenges

Involving families in service planning is a continuing challenge. The summary of findings, prepared by the Children's Bureau from the 2001-2004 reviews,²⁹ verifies that a common challenge in almost every State was the involvement of fathers, mothers, and children in case planning. In spite of this, our review of all 52 CFSR Final Reports found that only **three (3)** States discussed involving parents and families in mental health service delivery. In general, there was very little focus in the Final Reports on the participation of families in their own mental health services, in the services of their children, or in system-level planning.

Opportunities

Six (6) State PIPs identified strategies for improving family involvement in the planning and delivery of mental health services, primarily by adopting wraparound or system of care models, which promote a family-driven, family-centered approach. A few States described improving family access to and quality of mental health service planning processes.

Services for Family Members

Challenges

The 2001-2004 summary of findings prepared by the Children's Bureau also noted that service delivery for parents is a challenge for States, particularly substance abuse and mental health services;³⁰ however, in our review of the 52 Final Reports, only **seven (7)** States described a lack of mental health services for parents.

Opportunities

Twice that number (**14 States**) introduced measures in their PIPs to address the mental health needs of family members. These States described efforts to improve services for families, including identifying families' mental health needs early, linking families to a wide array of services, and implementing treatment models that provide services and supports to all family members.

Collaboration

Challenges

Even though **38** State Final Reports described cross-system collaborative efforts to build service capacity and meet the mental health needs of children in the child welfare system, many States described collaboration as a continual challenge, with successful service

²⁹ *General Findings from the Federal Child and Family Services Reviews*, p. 10 (See <http://www.acf.hhs.gov/programs/cb/cwmonitoring/results/index.htm>.)

³⁰ *General Findings from the Federal Child and Family Services Reviews*, p. 13 (See <http://www.acf.hhs.gov/programs/cb/cwmonitoring/results/index.htm>.)

coordination and access to certain services remaining problematic. The Reports emphasized how important it is for collaboration to be an ongoing process in order to resolve problems and issues as they arise.

In its content analysis of the FY 2002-2004 Final Reports ($N = 35$), the Children's Bureau identified the need for greater collaboration between the child welfare agency and external stakeholders as a common challenge in 15 States.³¹

Opportunities

Where cross-system problems existed, many communities and States were using cross-system strategies to address them, rather than have the child welfare system attempt solutions on its own. **Thirty-seven (37)** of the State PIPs proposed collaborative strategies to find solutions to both system-level problems and those related to individual children and families. These strategies included community-level partnerships, State-level cross-system governing bodies and task forces, cross-system Memoranda of Agreement, integration of funds, and restructuring of State agencies.

Twenty (20) States mentioned efforts to develop or expand existing community-based mental health systems of care for children and families to facilitate better access to quality mental health care for children and families who receive services from the child welfare system. State initiatives included establishing cross-system collaborations to coordinate and integrate mental health and other social services; developing and blending financial resources; and applying the system of care framework and its values to the practices, policies, and procedures of service provision.

ADDITIONAL CHALLENGES

Permanency and Stability

Thirty-three (33) State Final Reports demonstrated that many system challenges coalesced around the goals of permanency and stability for children. The complex behavioral health needs of children, along with the lack of early diagnosis, the lack of specialized providers to address needs, and insufficient well-trained and supported parents, foster parents, and social workers, led to placement disruptions, instability, and difficulty in establishing and reaching a permanent goal.

Providers/Rural Areas

States were challenged by a shortage of mental health providers skilled in treating the special issues presented by children and youth who have experienced the trauma associated with abuse, neglect, sexual abuse, multiple out-of-home placements, parental substance use, and

³¹Item 38 (systemic factor)—engages in ongoing consultation with stakeholders in developing the CFSR

domestic violence. **Sixteen (16)** States reported that the majority of mental health providers were clustered in and around urban areas and that many providers were unwilling to relocate to rural areas. **Thirteen (13)** States indicated problems with Medicaid that contributed to the provider shortage and caused some providers to be unwilling to participate in Medicaid. Only a few States described strategies for strengthening provider networks.

Funding

Eleven (11) States described the significant impact that budget deficits were having on the availability of appropriate mental health services, citing especially a narrowing of the population of children served by the public mental health system to those with the most serious emotional disorders.

ADDITIONAL OPPORTUNITIES AND SOLUTIONS

Comprehensive Strategies

As stated previously, when a PIP described three or more statewide strategies or action steps that focused on improving mental health services, we categorized this as a comprehensive strategy. It is encouraging that **almost half** of the PIPs reviewed indicated that States were taking a comprehensive approach to strengthening mental health services for children in the child welfare system. These States were engaged in many of the strategies described in Section 2 of this report.

Training

Three-fourths of the PIPs proposed training as one strategy for improving mental health services. States proposed to train child welfare staff, mental health clinicians, and foster parents on topics such as mental health practice guidelines, assessment protocols, service planning, the wraparound process, domestic violence, Medicaid eligibility, access to mental health services, evidence-based practices, adoption practice, the use of a common assessment tool, and recognition of underlying issues such as developmental disabilities and substance abuse needs of children and families. Several States described strategies for institutionalizing their training programs, including developing partnerships with universities and statewide training academies. **One (1)** State created an Assistant Commissioner for Training position to lead the training effort across the child welfare agency and to develop a training academy.

Policy Development and Implementation

Our summary of the PIPs highlights the creative and multifaceted use of mental health policy development and reform as a strategy for facilitating systemic and organizational change. States were addressing both the content and processes associated with policy reform, including creating new mental health interventions; improving coordination, collaboration, and oversight; and offering staff development opportunities. The assessment of child mental health needs was a primary focus for policy development and reform in **21** States.

Tracking and Monitoring Services Received and Child/Family Outcomes Achieved

Almost half of the PIPs described strategies for tracking and monitoring the receipt of mental health assessments and services, as well as the quality and impact (child and family outcomes) of the services received. They were doing this in a variety of ways, such as documentation in case records (electronic and paper), the use of existing quality assurance systems, supervisory review, case review processes, systematic entry of data into information systems, and provider performance monitoring.

Our analysis and CFSR data from Children's Bureau reports clearly establish the challenges to meeting the mental health needs of children and families in the child welfare system, as well as the necessity and importance of the improvements that are taking place.

SECTION
4

Issues for Further Consideration and Study

SECTION 4 describes issues that would benefit from further study:

Disproportionality and cultural competence

Evidence-based practices

Provider issues

Family involvement in service planning and services for family members

Substance abuse services

The process used in this analysis included a word search focused on behavioral health terms, as well as a close examination of certain sections of the Final Reports and the PIPs (see Methodology on p. 13 and p. 69). Given the limitations of the word search methodology and the information that States did and did not include in the Final Reports and PIPs, we acknowledge that States may be doing significant work that was not fully reported. While acknowledging the limitation of the information available to us, we present several critical issues that would benefit from further study.

DISPROPORTIONALITY AND CULTURAL COMPETENCE

We had expected to discuss the issue of cultural competence in providing mental health services for children and families, but very few Final Reports and PIPs described challenges or solutions related to cultural issues. We found some information about cultural competence in sections of the reports outside our word search; however, we found very little discussion of how to make mental health services for children in the child welfare system more culturally competent. **One (1)** State acknowledged a lack of culturally and linguistically appropriate services, particularly for psychological evaluations and diagnoses; **one (1)** other State found that services were not consistently individualized to meet cultural, language, and other unique needs of families and children. Only **one (1)** State set specific action steps for achieving culturally competent mental health services for children in the child welfare system.

This situation is of concern because of the disproportionate presence of children of color, especially African American and Native American children, in the child welfare system. Evidence from a national study suggested that the nonclinical factor of race/ethnicity predicts lower use of mental health care for African American youth in the child welfare system.³² Another study of the same population of youth found that coordination between child welfare and mental health agencies may increase the effect of clinical factors and decrease the impact of nonclinical factors such as race/ethnicity in the use of mental health care.³³ Given the benefit of such cross-system coordination, it is important to further study and understand the use of mental health services by children of all cultures. The absence of culturally and linguistically competent mental health and substance abuse services for children and their families may contribute to the disproportionate number of children of color in out-of-home placements.

EVIDENCE-BASED PRACTICES

Both the mental health system and the child welfare system are concerned with providing services that are effective and that achieve the outcomes that children and families desire. There is a movement toward “evidence based practices,” including dissemination of information about such practices and discussion of how to implement them. Although the Final Reports and the PIPs mentioned services that had some evidence base (e.g., treatment foster care, multi-systemic therapy, the wraparound process), we found that only **six (6)** States described concerted efforts to implement evidence-based practices that work for children in the child welfare system:

- Developing a competent workforce trained in evidence based practices (**1 State**)
- Creating a State-level institute to conduct research and develop and implement evidence-based interventions for children who have suffered sexual abuse, physical abuse, exposure to domestic violence, and other trauma (**1 State**)
- Developing intensive, home-based services including multi-systemic therapy and wraparound services that include services for all family members (**4 States**)

In a review of the research literature on mental health care for children in foster care, Landsverk and colleagues noted that overall, little evidence suggests that measurable benefit in lowered mental health symptom levels or increased functioning can be expected from the receipt of “usual” mental health care in public mental health community settings that serve children and adolescents reported to child protective services and those who experience foster care. This has led to a sharp focus on bringing into these settings the therapeutic

³²Garland, A. F., Landsverk, J. A., & Lau, A. S. (2003). Racial/ethnic disparities in mental health service use among children in foster care. *Children & Youth Services Review, 25*(5-6), 491-507.

³³Hurlburt, M. S., Leslie, L. K., Landsverk, J., Barth, R. P., Burns, B. J., Gibbons, R. D., Slymen, D. J., & Zhang, J. (2004). Contextual predictors of mental health service use among children open to child welfare. *Archives of General Psychiatry, 61*(12), 1217-1224.

interventions that have better potential for addressing the mental health problems of these children and youth.³⁴ It would be interesting to study further whether and how States are exploring using evidence-based practices through their Program Improvement Plans.

PROVIDER ISSUES

The Final Reports and PIPs clearly identified a scarcity of mental health services in States and a shortage of mental health providers experienced and skilled in treating the special issues presented by children and families involved with child welfare. A significant contributing factor to the provider shortage was the lack of providers who participated in the Medicaid program. Given the significance of this problem, we expected to find multiple strategies in the PIPs for addressing it. Instead, only a few States described strategies for recruiting, training, and offering incentives to mental health providers. This lack of attention to working with providers is troubling for another reason. **Thirty-seven (37)** States described in their PIPs multiple strategies for assessing their service needs and expanding the service array. It will be extremely difficult to put new services in place (even if there is a funding source) without a strong network of qualified providers. Our review found little evidence of strategies for strengthening provider networks. Further study of this would be beneficial.

FAMILY INVOLVEMENT IN SERVICE PLANNING AND SERVICES FOR FAMILY MEMBERS

There is a growing understanding that achieving successful treatment outcomes requires child and family engagement in the process and a commitment to change. Research has increasingly demonstrated that family engagement in children's behavioral health services is central to improving the delivery of services and the outcomes achieved for children and their families.^{35,36} The Children's Bureau case-level analyses also found a significant association between State ratings on achieving permanency and stability for children and the involvement of children and families in case planning.³⁷ Given the value of family involvement, it is important to explore further why only **six (6)** PIPs discussed strategies for improving family involvement in the planning and delivery of mental health services. We also found almost no discussion of involving parents in system-level change, design, and decisions.

³⁴Landsverk, J. A., Burns, B. J., Stambaugh, L. F., & Reutz, J.A. (2006). *Mental health care for children and adolescents in foster care: Review of research literature* (pp. 23-25). Seattle, WA: Casey Family Programs.

³⁵Knitzer, J. (1993). Children's mental health policy: Challenging the future. *Journal of Emotional and Behavioral Disorders, 1*(1), 8-16.

³⁶Bruns, E. J., Walker, J. S., Adams, J., Miles, P., Osher, T. W., Rast, J., VanDenBerg, J. D., & National Wraparound Initiative Advisory Group. (2004, March). *Toward a better understood and implemented Wraparound*. 17th Annual System of Care Research Conference, Tampa FL.

³⁷*General Findings from the Federal Child and Family Services Review, Case-Level Analyses* (See www.acf.hhs.gov/programs/cb/cwmonitoring/results/genfindings04/ch2.htm.)

The 2001-2004 Summary of Findings prepared by the Children's Bureau described service delivery for parents as a challenge to States and found insufficient services for parents, particularly substance abuse treatment and mental health services.³⁸ However, only **seven** (7) Final Reports noted a lack of mental health services for parents. Further study is needed to understand why so few States indicated a lack of mental health services for parents.

SUBSTANCE ABUSE SERVICES

Issues related to substance abuse are core concerns for families and youth involved with the child welfare system, and the lack of capacity for treatment continues to be a source of frustration. Although this analysis is related to the mental health system, as we reviewed the mental health sections of the Final Reports and Program Improvement Plans, we saw significant substance abuse issues in many States.

The National Center on Substance Abuse and Child Welfare (NCSACW), an initiative of the Department of Health and Human Services' Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, and the Administration for Children and Families, Children's Bureau's Office on Child Abuse and Neglect, has completed a summary and analysis of CFSRs and PIPs that highlights the substance abuse issues in the States' reports. This report can be found at <http://www.ncsacw.samhsa.gov/files/SummaryofCFSRs.pdf>.

³⁸ *General Findings from the Federal Child and Family Services Reviews*, p. 13 (See <http://www.acf.hhs.gov/programs/cb/cwmonitoring/results/index.htm>.)

PROCESS, STRUCTURE, AND ADDITIONAL RESOURCES

Values and Principles

The reviews promote practice principles that support improved outcomes for children and families, such as family-centered practice, community-based services, strengthened parental capacity to protect and provide for their children, and individualized services that respond to the unique needs of children and families.

Structure

Each Child and Family Services Review (CFSR) is a two-stage process that comprises a statewide self-assessment and an onsite review of child and family service outcomes and program systems. (See Appendix B for specific outcomes, indicators, and systemic factors.)

Statewide Self-Assessment

The Statewide Assessment is completed during the six-month period prior to the onsite review by a team of State agency staff and other State representatives who are not staff of the State agency. It includes an analysis of data indicators that address safety and permanency issues for children served by the agency. It helps guide certain decisions about the onsite review, such as the locations in the State where onsite review activities will occur and the composition of the sample of cases to be reviewed onsite. States are encouraged to include a wide range of stakeholders in the Statewide Assessment.

Onsite Review

After the statewide assessment has been completed, an onsite review of the State child welfare system is conducted by a joint Federal-State team. The review takes place in three political subdivisions in the State, one of which includes the city with the largest population. The onsite portion of the review has three parts: (1) case record reviews (30 to 50 per State); (2) interviews with children and families engaged in services; and (3) interviews with community stakeholders, such as the courts, other child-serving agencies and community organizations, foster families, social workers, and service providers.

*Information in this description was adapted from summaries provided by the Administration for Children and Families; by the Division of Child and Family Services, Utah Department of Human Services; and from remarks made by Jerry Milner and Joan Ohl of the Administration for Children and Families at the Annual Meeting of States and Tribes in January 2003.

The Administration for Children and Families (ACF) makes a separate determination about the State's conformity with each of the seven outcomes and seven systemic factors following the onsite review, and confirms the determination of conformity to the State in a written report issued within 30 days of the onsite review.

Program Improvement Plans

For any of the outcomes or systemic factors in which the State is determined not to be in substantial conformity, the State must develop and implement a program improvement plan (PIP) designed to correct the area of nonconformity. The PIP must be developed and submitted to the Regional Office for approval within 90 days of the State receiving written notification of nonconformity. The Children's Bureau supports States with technical assistance and monitors the implementation of their PIPs.

Penalties

Penalties are assessed commensurate with the level of nonconformity from a pool of Federal funds comprising a State's Title IV-B allocation and a portion of its Title IV-E allocation. The initial penalty is 1% of the pool for each of the seven outcomes or seven systemic factors determined not to be in substantial conformity. The penalty increases to 2% and 3% on subsequent reviews if the State has not successfully implemented a PIP. Penalties associated with nonconformity are suspended while the State implements the approved PIP and are rescinded if the State is successful in ending the nonconformity through completion of the PIP.

ADDITIONAL RESOURCES AND WEB SITES

Children's Bureau

The Children's Bureau Web site (www.acf.hhs.gov/programs/cb/cwmonitoring/index.htm) updates information relating to the Child and Family Services Reviews, including consultant recruitment information, training materials, and reports on the key findings of the reviews. *The Child and Family Services Reviews Procedures Manual* and review instruments also are available on the Children's Bureau Web site.

The Child Welfare Monitoring Documents Library

This searchable online library contains full-text and printable versions of reports from the first round of the Child and Family Services Reviews:
http://basis.caliber.com/cwig/ws/cwmd/docs/cb_web/SearchForm

The following reports are available for each State, the District of Columbia, and Puerto Rico:

- **Statewide Assessments**—Prior to its onsite review, each State assesses its child welfare data in light of the outcomes for children and families subject to review. In addition, the assessment must address the systemic issues under review relative to the State's capacity to deliver effective services.

- **Child and Family Services Review (CFSR)**—The Child and Family Services Review assesses State performance during a specified time period with respect to seven child welfare outcomes in the areas of safety, permanency, and well-being and with respect to seven systemic factors.
- **State-by-State Key Findings From the CFSR Report**—These key findings are from the State Child and Family Services Reviews.
- **Program Improvement Plan (PIP)**—A State not in conformity with the seven outcomes and the seven systemic factors must prepare a Program Improvement Plan (PIP) that includes action steps and benchmarks for bringing the State into conformity.

Child and Family Services Review Measures for Round 1

OUTCOMES, INDICATORS, AND SYSTEMIC FACTORS

The first round of Child and Family Service Reviews examined outcomes for children and families in three areas: safety, permanency, and child and family well-being. Within these three areas, seven outcomes were assessed through Statewide data and review of cases. These seven outcomes have 23 indicators (called items).

SAFETY

Safety Outcome 1 *Children are first and foremost protected from abuse and neglect*

Item 1: Timeliness of investigations

Item 2: Repeat maltreatment

Safety Outcome 2 *Children are safely maintained in their homes when possible and appropriate*

Item 3: Services to prevent removal

Item 4: Risk of harm

PERMANENCY

Permanency Outcome 1 *Children have permanency and stability in their living situations*

Item 5: Foster care re-entry

Item 6: Stability of foster care placements

Item 7: Permanency goal for child

Item 8: Reunification, guardianship, and placement with relatives (for FY 2002). Independent living services (for 2001)

Item 9: Adoption

Item 10: Other planned living arrangement

Permanency Outcome 2 *The continuity of family relationships and connections is preserved*

- Item 11: Proximity of placement
- Item 12: Placement with siblings
- Item 13: Visiting with parents and siblings in foster care
- Item 14: Preserving connections
- Item 15: Relative Placement
- Item 16: Relationship of child in care with parents

WELL-BEING

Well-Being Outcome 1 *Families have enhanced capacity to provide for children's needs*

- Item 17: Needs/services of child, parents, and foster parents
- Item 18: Child/family involvement in case planning
- Item 19: Worker visits with child
- Item 20: Worker visits with parents

Well-Being Outcome 2 *Children receive services to meet their educational needs*

- Item 21: Educational needs of child

Well-Being Outcome 3 *Children receive services to meet their physical and mental health needs*

- Item 22: Physical health of the child
- Item 23: Mental health of the child

SYSTEMIC FACTORS

The reviews also examined seven systemic factors that affect the quality of services delivered to children and families and the outcomes they experience. The Statewide assessment included the State's evaluation of Federal requirements related to each systemic factor. During the onsite review, selected State and community stakeholders were interviewed to determine how well each systemic factor functions in the State. The systemic factors follow:

- | | |
|-------------------------------------|--|
| Statewide Information System | Item 24: System can identify the status, demographic characteristics, location, and goals of children in foster care |
| Case Review System | <ul style="list-style-type: none"> Item 25: Process for developing a case plan and for joint case planning with parents Item 26: Process for 6-month case reviews Item 27: Process for 12-month permanency hearings Item 28: Process for seeking TPR in accordance with ASFA Item 29: Process for notifying caregivers of reviews and hearings and for opportunity for them to be heard |

Quality Assurance System	Item 30: Standards to ensure quality services and ensure children's safety and health
	Item 31: Identifiable QA system that evaluates the quality of services and improvements
Training	Item 32: Provision of initial staff training
	Item 33: Provision of ongoing staff training that addresses the necessary skills and knowledge.
	Item 34: Provision of training for caregivers and adoptive parents that addresses the necessary skills and knowledge
Service Array	Item 35: Availability of services
	Item 36: Accessibility of services in all jurisdictions
	Item 37: Ability to individualize services to meet unique needs
Agency Responsiveness to the Community	Item 38: Engages in ongoing consultation with critical stakeholders in developing the CFSP
	Item 39: Develops annual progress reports in consultation with stakeholders
	Item 40: Coordinates services with other Federal programs
Foster and Adoptive Parent Licensing, Recruitment, and Retention	Item 41: Standards for foster family and child care institutions
	Item 42: Standards are applied equally to all foster family and child care institutions
	Item 43: Conducts necessary criminal background checks
	Item 44: Diligent recruitment of foster and adoptive families that reflect children's racial and ethnic diversity
	Item 45: Uses cross-jurisdictional resources to find placements

DATA COMPOSITES AND SUBSTANTIAL CONFORMITY³⁹

Round 2 of the CFSR began in FY07. While this mental health analysis does not address Round 2, the following information on changes in the CFSR process that will affect all States in Round 2 is provided. These changes were made to enhance the quality of the CFSR.

ADDITION OF DATA COMPOSITES

- Round 1 used six single statewide data measures for which national standards were established.
- Round 2 uses two statewide data indicators and four statewide data composites that are compared to the national standard. The composites incorporate a wider range of performance areas relevant to a particular child welfare domain.
- A composite measure is made up of separate components to reflect the general area that is assessed by the data.

Data Indicators from CFSR Round 1

The following two performance measures and national standards were used during Round 1 of the CFSR as part of the assessment of a State's substantial conformity with CFSR **Safety Outcome 1**—*Children are, first and foremost, protected from abuse and neglect*:

1. Repeat maltreatment—Of all children who were victims of substantiated or indicated child abuse and/or neglect during the first 6 months of the reporting period, 6.1 percent or less had another substantiated or indicated report within a 6-month period.
2. Maltreatment of children in foster care—Of all children who were in foster care during the reporting period, 0.57 percent or less were the subject of substantiated or indicated maltreatment by a foster parent or facility staff member.

³⁹The information in Appendix C was adapted from the National Resource Center for Child Welfare Data and Technology Tool Kit: http://www.nrccwdt.org/cfsr/cfsr_toolkit.html

The following four performance measures and national standards were used as part of the assessment of a State's substantial conformity with CFSR **Permanency Outcome 1**—*Children have permanency and stability in their living situations*:

1. Timeliness of reunification—Of all children who were reunified with their parents or caretakers at the time of discharge from foster care, 76.2 percent or more were reunified in less than 12 months from the time of the latest removal from home.
2. Re-entry into foster care—Of all children who entered foster care during the reporting period, 8.6 percent or less were re-entering foster care in less than 12 months of a prior foster care episode.
3. Timeliness of adoption—Of all children who exited foster care to a finalized adoption, 32 percent or more exited foster care in less than 24 months from the time of the latest removal from home.
4. Placement stability—Of all children who have been in foster care for less than 12 months from the time of the latest removal from home, 86.7 percent or more have had no more than two placement settings.

Data Indicators from CFSR Round 2

Two individual measures, rather than composites, will be used as part of the assessment of substantial conformity with CFSR **Safety Outcome 1**.

1. Safety Measure 1: Recurrence of maltreatment. Of all children who were victims of substantiated or indicated abuse or neglect during the first 6 months of the reporting year, what percent did not experience another incident of substantiated or indicated abuse or neglect within a 6-month period?
2. Safety Measure 2: Maltreatment of children in foster care. Of all children in foster care during the reporting period, what percent were not victims of a substantiated or indicated maltreatment by foster parents or facility staff members?

These measures are similar to those used in the first round of the CFSR, except their complements are used. In other words, the focus has shifted from the occurrence of maltreatment to the absence of maltreatment.

Data Composites and Measures from CFSR Round 2

Within CFSR **Permanency Outcome 1**, the four individual indicators listed above have been replaced with four composite measures.

Permanency Composite 1: Timeliness (3 measures) and permanency (1 measure) of reunifications.

Permanency Composite 2: Timeliness of adoptions

Component A—Timeliness of adoptions of children exiting foster care (2 measures)

Component B—Progress toward adoption of children who have been in foster care for 17 months or longer (2 measures)

Component C—Timeliness of adoptions of children who are legally free for adoption (1 measure)

Permanency Composite 3: Achieving permanency for children in foster care

Component A—Achieving permanency for children in foster care for extended periods of time (2 measures)

Component B—Children growing up in foster care (1 measure)

Permanency Composite 4: Placement stability (3 measures)**Well-being Measures**

Because neither NCANDS⁴⁰ nor AFCARS⁴¹ collects information pertaining to child well-being, there are no data measures that capture this information. However, the case review process will continue to assess State performance on outcomes relevant to the well-being of children and families.

SUBSTANTIAL CONFORMITY

In Round 1, States were required to substantially achieve the outcome in 90% of the cases reviewed on-site to be considered in substantial conformity. In Round 2, States will be required to substantially achieve the outcome in 95% of the cases reviewed on-site to be considered in substantial conformity. In Round 1, 50 cases were reviewed on-site. In Round 2, 75 cases will be reviewed.

For further information, please see the National Resource Center for Child Welfare Data and Technology 2006 State Data Profile Toolkit.

The NRC-CWDT has created a new toolkit to help you understand and work with the new composite measures for Round Two of the CFSR. The 2006 State Data Profile Toolkit contains a general overview of the CFSR initiative, an introduction to the data used in the CFSR State Data Profile (the Profile), a detailed explanation of the Profile, and a guide to formulating relevant questions based on the specific results from Profile. Additionally, it contains a Quick Reference Guide to the CFSR State Data Profile Elements, a CFSR Glossary, a generic discussion of composite measures and weighted components, as well as other useful documents and tools: http://www.nrccwdt.org/cfsr/cfsr_toolkit.html

⁴⁰National Child Abuse and Neglect Data System

⁴¹Adoption and Foster Care Analysis and Reporting System

A set of generally accepted qualitative procedures was used to perform content analysis on the 52 CFSR Final Reports and PIPs. Content analysis is a qualitative technique that involves drawing inferences from written documents or transcriptions by systematically and objectively identifying the meaningful characteristics and patterns of messages they convey. The use of this and other qualitative techniques does not involve testing a hypothesis but rather assumes that theory is created from the ground up by using the data to guide the formation of ideas, inferences, and patterns.⁴² The procedures we used to engage in this process involved a multi-step, multi-stage process:

- Reducing the data into meaningful and manageable amounts
- Developing and assigning codes to relevant content
- Using the codes to create categories that reflected emerging themes and patterns in the data
- Reorganizing, analyzing, and summarizing the material within the identified categories
- Verifying the relevance and accuracy of analysis and summaries through a process involving extensive discussion and consensus seeking among the authors

To identify relevant content from the 52 CFSR Final Reports and Program Improvement Plans (PIPs), the sections related to Well-Being Outcome 3 (*children receive adequate services to meet their physical and mental health needs*) and Item 23 (*mental health of the child*) were extracted from each Final Report and PIP for further review and study. We also reviewed Well-Being Outcome 1 (*families have enhanced capacity to provide for their children's needs*), Item 17 (*needs and services*), and two Systemic Factors: 5—Service Array (Items 35-37) and 6—Agency Responsiveness to the Community (Item 38-40). All of these sections were reviewed in their entirety. A word search was also conducted to locate information about mental health issues in other sections of the Final Reports and PIPs. The following words were used in this preliminary search:

- Mental health (mental)
- Emotional (emot)
- Therapy/Therapeutic (therap)
- Behavioral (behav)

⁴²Berg, B. L. (2001). *Qualitative research methods for the social sciences* (Vol. 4). Long Beach, CA: Allyn & Bacon.

- Counseling (counsel)
- Psychology/Psychological/Psychiatry/Psychiatric (psych)
- Wraparound (wraparound, wrap around)

The material extracted from the CFSR Final Reports provided the starting point for creating codes that reflected emerging trends within and across the States, as well as content related to the well-being outcomes and systemic factors described above. Atlas ti was used to locate relevant material and assign these codes. The following codes generated from this process served as a framework for organizing and summarizing the results of the Final Reports reviewed in this analysis:

Code: 06 SF
 Code: 17 ITEM
 Code: 23 ITEM
 Code: 35 ITEM
 Code: 36 ITEM
 Code: 37 ITEM
 Code: 38 ITEM
 Code: 39 ITEM
 Code: 40 ITEM
 Code: Collaborative Strategies
 Code: Coordination/Collaboration
 Code: Data Collection
 Code: Family Involvement
 Code: Family Services
 Code: Funding Issues
 Code: MH Assessments
 Code: MH Assessments—Policy
 Code: MH Assessments—Receipt
 Code: MH Services
 Code: MH Services—Provision
 Code: MH Services—Scarcity
 Code: Other
 Code: Permanency and Stability
 Code: Promising Practice
 Code: Provider Issues
 Code: Rural/Urban Issues
 Code: Training
 Code: Trends—Other

Material was extracted from the PIPs for review using the same key words, phrases, and well-being and system outcome sections that were used to identify relevant content from the Final Reports, as mentioned above. PIPs were then coded using the same codes generated from the analysis of the Final Reports. By using these same codes, we could more readily identify State responses (including strategies and solutions) to the issues and challenges addressed in the Final Reports. This process also led to the identification of the following additional codes that reflected new emerging content in the PIPs.

- Comprehensive Strategies to Develop Mental Health Service System
- Continuing Challenges
- Issues for Further Consideration
- Mental Health Services—Building Array/Capacity
- Mental Health Service Planning
- Monitoring/Outcomes
- Need for Mental Health Technical Assistance
- PIP—Mental Health Issues Mentioned
- PIP Action Steps Relate to Mental Health
- PIP Goals Address Mental Health Issues
- PIP Replicating Systems of Care
- PIP Team—Family Involvement;
- PIP Team—Mental Health Stakeholders
- Policy Development/Implementation
- Solutions

Each State PIP was coded and then entered in an Access database. Data reports were created in Access that reflected the results of each code across each State. These reports provided a way of displaying the coded PIP data in a format that was easy to summarize and analyze. Each data report was reviewed and discussed by at least two of the authors to ensure that the content was coded accurately and reliably and that summaries were based on the data available rather than on author bias or other extraneous factors.

APPENDIX

E

List of
Acronyms

ACF	Administration for Children and Families	GLBT	Gay, Lesbian, Bisexual, and Transgender
ADHD	Attention Deficit Hyperactivity Disorder	GUCCHD	Georgetown University Center for Child and Human Development
CAMHD	Children and Adolescent Mental Health Division	HHS	Health and Human Services
CASSP	Child and Adolescent Service System Program	IFA	Initial Family Assessment
CB	Children's Bureau	MH	Mental Health
CFSR	Child and Family Services Review	MIS	Management Information System
CHINS	Children in Need of Services	MOA	Memorandum of Agreement
CPPC	Community Partnerships for Protecting Children	MOU	Memorandum of Understanding
CPS	Child Protective Services	NCSACW	National Center on Substance Abuse and Child Welfare
CSAP	Center for Substance Abuse Prevention	NRC-CWDT	National Resource Center for Child Welfare Data and Technology
CSAT	Center for Substance Abuse Treatment	PIP	Program Improvement Plans
CW	Child Welfare	QA	Quality Assurance
CWS	Child Welfare Services	RN	Registered Nurse
CWTI	Child Welfare Training Institute	SAMHSA	Substance Abuse and Mental Health Services Administration
DCFS	Department of Children and Family Services	SCHIP	State Children's Health Insurance Program
DCYF	Department of Children, Youth and Families	SEBD	Support for Emotional and Behavioral Development
DD	Developmental Disabilities	SED	Serious Emotional Disturbance/Disorder
DOH	Department of Health	SOC	System of Care
EPSDT	Early Periodic Screening, Diagnosis, and Treatment	TA Center	Technical Assistance Center
FCCP	Family Care Coordinating Programs	TA Partnership	Technical Assistance Partnership
FCSC	Family and Community System of Care	TAP	Technical Assistance Partnership

F Systems of Care

SYSTEM OF CARE DEFINITION FROM THE FEDERAL CENTER FOR MENTAL HEALTH SERVICES

A system of care is about partnership—a partnership made up of service providers, families, teachers, and others who care for a child. Together, the team develops an individualized service plan that builds on the unique strengths of each child and each family. This customized plan is always implemented in a way that is consistent with the family’s culture and language.

In a system of care, mental health, education, child welfare, juvenile justice, and other agencies work together to ensure that children with mental, emotional, and behavioral problems and their families have access to the services and supports they need to succeed. These services and supports may include diagnostic and evaluation services, outpatient treatment, emergency services (24 hours a day, 7 days a week), case management, intensive home-based services, day treatment, respite care, therapeutic foster care, and services that will help young people make the transition to adult systems of care.

Systems of care are developed on the premise that the mental health needs of children, adolescents, and their families can be met within their home, school, and community environments. These systems are also developed around the principles of being child-centered, family-driven, strength-based, and culturally competent and involving interagency collaboration. The Child, Adolescent, and Family Branch embrace and promote these core principles of systems of care.

The goal of systems of care programs is to build innovative community treatment programs for children with serious emotional disturbances and their families.

*Source: National Mental Health Information Center, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, Department of Health and Human Services:
<http://mentalhealth.samhsa.gov/cmhs/ChildrensCampaign/grantcomm.asp>*

CORE VALUES

1. A system of care should be child centered and family focused, with the needs of the child/youth and family dictating the types and mix of services provided.
2. A system of care should be community based, with the locus of services as well as management and decision-making responsibility resting at the community level.
3. A system of care should be culturally competent, with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve.

GUIDING PRINCIPLES

1. Children/youth with emotional disturbances should have access to a comprehensive array of services that address their physical, emotional, social, and educational needs.
2. Children/youth with emotional disturbances should receive individualized services in accordance with the unique needs and potentials of each child/youth and guided by an individualized service plan.
3. Children/youth with emotional disturbances should receive services within the least restrictive, most normative environment that is clinically appropriate.
4. The families and surrogate families of children/youth with emotional disturbances should be full participants in all aspects of the planning and delivery of services.
5. Children/youth with emotional disturbances should receive services that are integrated, with linkages between child-serving agencies and programs and mechanisms for planning, developing, and coordinating services.
6. Children/youth with emotional disturbances should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner and that they can move through the system of services in accordance with their changing needs.
7. Early identification and intervention for children/youth with emotional disturbances should be promoted by a system of care in order to enhance the likelihood of positive outcomes.
8. Children/youth with emotional disturbances should be ensured smooth transitions to the adult service system as they reach maturity.
9. The rights of children/youth with emotional disturbances should be protected, and effective advocacy efforts for children and adolescents with emotional disturbances should be promoted.
10. Children/youth with emotional disturbances should receive services without regard to race, religion, national origin, sex, physical disability, or other characteristics, and services should be sensitive and responsive to cultural differences and special needs.

Source: Stroul, B & Friedman, R. (1986). A system of care for children and youth with severe emotional disturbances (rev. ed., p. 17). Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

SYSTEM CHANGE AND IMPROVING CHILD WELFARE OUTCOMES THROUGH SYSTEMS OF CARE

Increasingly, the system of care values and principles initially articulated in relation to children with serious disorders are being applied in all system of care building, and are equally applicable to systems of care for all children. A system of care, by definition, is non-categorical. It crosses agency and program boundaries and approaches the service and support requirements of families holistically. It adopts a population focus across systems.⁴³

As discussed in this CFSR analysis, many States are using the CFSR process, and especially PIP development, as an opportunity to generate system change. They recognize that no single agency can provide all necessary services and supports for families with children who are vulnerable to child abuse and neglect. Agencies are building collaborative relationships with mental health, substance abuse, domestic violence, education, and judicial systems, as well as the private sector. During the last 20 years, the Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration has managed the system of care program described above⁴⁴ for children with serious emotional disorders. Sparked by the promising outcomes for families and children served by this program, in 2003, the Children's Bureau of the Administration for Children and Families funded the Improving Child Welfare Outcomes through Systems of Care Initiative. This initiative is designed to test the effectiveness of applying systems of care principles and infrastructure to the child welfare population, to promote more effective collaboration among child-serving agencies, and to improve CFSR outcomes.⁴⁵

⁴³Adapted from: Pires, Sheila. (2002). *Building Systems of Care: A Primer*. Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University.

⁴⁴Comprehensive Community Mental Health Services for Children and Their Families Program (P.L.102-321)

⁴⁵Adapted from: DeCarolis, G., Southern, L., Blake, F. (2007). *Building the Infrastructure to Support a Child Welfare Driven System of Care, A Guide for Communities*.